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Methods University Health System Can Use to Expand Medicaid Coverage to Uninsured Poor Parents with Medicaid Eligible Children: Policy Analysis

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Abstract

Bexar County, low-income, uninsured parents with Medicaid- eligible children have been negatively impacted by reductions in Medicaid eligibility standards made by the Texas State Legislature in 2003 and the continuing reduction in local employer sponsored insurance. The cost for providing healthcare to this population has fallen to Bexar County residents through local taxes in support of the county hospital, University Health System. Alternatives to improve access to care for this population while reducing cost to the county are limited. A 1115 Medicaid waiver requiring a premium cost share with small business, employees and county indigent care funds is currently the best long term solution and will increase access and assist in mitigating some healthcare costs for the county.

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Introduction

The lack of health insurance for parents of Medicaid eligible children is a national problem. Lack of adequate insurance affects parents' ability to access care, which directly affects their health. Maintaining a healthy population means people are more able to work, buy goods, and pay taxes that contribute to a healthy economy. Many low-income working parents historically relied on Medicaid for access to medical care if local businesses did not provide a health insurance plan. Federal and state budget cuts since 2003 have slowly decreased the availability of Medicaid and weakened an already frayed safety net.

Bexar County, low-income, uninsured parents with Medicaid-eligible children, impacted by continuing state reductions in Medicaid eligibility and a lack of affordable employer sponsored insurance, continue to struggle to access healthcare. Bexar County taxpayers, through local taxes in support of University Health System, pay the cost for providing healthcare to this population. Continuing to be good stewards of local tax dollars requires a constant search for new and innovative alternatives to fund the growing healthcare needs of local working uninsured low-income parents. The mission of the University Health System is to promote the good health of the community by providing the highest quality of care to both inpatients and outpatients, by teaching the next generation of health professionals and supporting research thereby advancing medical knowledge and improving the delivery of patient care. University Health System is bound by this mission and has assumed the duty as the primary safety net provider for the uninsured and indigent residents of Bexar County.

Ongoing state government initiatives to reduce medical spending have hampered the execution of those duties. Specific projected state revenue cuts that will effect University Health

System in 2006 include canceling the Medically Needy program for adults, a $13.1M annual loss; a reduction in General Medical Education Support, $3.9M annual loss; Medicaid rate cuts, a $5.3M annual loss; and a decline in Disproportionate Share Hospital and Upper Payment Limits, a $19.7M annual loss. Despite a projected revenue of $165.7M in 2006 from county taxes, there will be a $62.1M shortfall to cover the Bexar County indigent care expense of $227.8M (Hernandez, 2005). Federal and state Medicaid cuts continue shifting the burden of covering the uninsured to local governments presenting a fiscal challenge for the health system and the residents of Bexar County.

State Medicaid budget cuts from 2003 exacerbated an already burgeoning healthcare problem for poor parents looking for options to obtain healthcare coverage in Bexar County. In 2003, Governor Rick Perry wrote in a letter to the 78th Legislature that Texas would have $7.4B less in general revenue and that Texas' spending had outpaced the state's economy (Perry, 2003). To address the deficit, Texas adopted various cost cutting and avoidance strategies. Notable areas in which funding was cut or cancelled included reducing teacher's health insurance stipends, reducing the budget of the Texas Department of Criminal Justice, eliminating various state agencies, and losing the funding for the Healthy Families Child Abuse Protection Program and Medicaid cuts to reduce caseloads.

Specific 2003 Medicaid cuts included elimination of the Medically Needy Program for a savings of $45.8M and elimination of many optional services for adults including mental health counseling, eyeglasses and hearing aids for a savings of $43.4M (Hill, 2004). The Medically Needy Program is designed on the premise that income and asset limits for Medicaid eligibility are fixed variables, but if an individual has extensive medical expenses, he may still qualify for Medicaid by subtracting those expenses. The program provided temporary Medicaid benefits for

poor parents with catastrophic medical bills. The 78th Legislature rationale was to reduce the states medical spending rather than raise the consumption taxes (Dunkelberg, 2005). As one of the few states in the union without a state income tax, it is politically easier to cut medical program funding rather than raise taxes for the general population to support education and infrastructure.

According to the Center for Public Policy Priorities, the continuing elimination of the Medically Needy Program for parents will result in a monthly average of over 10,900 poor parents in Texas having no Medicaid coverage in fiscal year 2007 (Dunkelberg, 2005). Prior to the cuts, working parents earning more than $395 per month for a family of three could have no more than $2,000 in resources based on the fixed income and asset limits mentioned previously to be eligible for Medicaid. Resources include items such as savings accounts, automobiles, convertible investments, and property (Dunkelberg).

Because the Texas Legislature only meets every two years to pass new legislation, the 2003 program cuts were not addressed again until 2005. The 2005 79th Texas Legislature chose not to reinstate the Medically Needy Program unless the largest local county governments (San Antonio, Austin, Houston, Corpus Christi, Dallas, El Paso, Fort Worth, Lubbock, and Midland Odessa) voluntarily put up $35M in local tax funds to pay for it (Dunkelberg, 2005). The 2005 proposal to use county tax revenue to receive the federal matching funds presents an extraordinary dilemma for the largest health systems in the state. Should the taxpayers in those select counties fund a public assistance program for the entire state because the state government cannot earmark the general revenue to support it?

The elimination of the Medically Needy Program leaves the Temporary Assistance for Needy Families as the only option available for low-income uninsured parents with

Medicaid/SCHIP eligible children to receive adult Medicaid. Temporary Assistance for Needy Families, historically known as welfare, is the monthly cash assistance program for poor families with children under age 18. Adults eligible for Temporary Assistance for Needy Families are automatically eligible for Medicaid. The 78th and 79th Texas Legislatures chose to keep eligibility standards for Temporary Assistance for Needy Families at the lowest allowed federal poverty level of 14%. The income cap for Temporary Assistance for Needy Families in Texas remains at the legislatively-imposed year to year fixed income cap of $188 per month for a family of three ($308 if one parent is working) (Dunkelberg, 2005). This income cap bars low-income working parents with incomes above 14% of the federal poverty level to qualify for Medicaid. Compared to the national Temporary Assistance for Needy Families cap average of $546 per month, or 43% above the federal poverty level, the Texas government has not increased the income level cap (14%) for poor parents with Medicaid eligible children in 20 years (Dunkelberg).

States have the authority to increase the Temporary Assistance for Needy Families income cap for parents to any income level it chooses, without a federal Medicaid waiver. To better illustrate the disparity that currently exists, a parent of two children bringing home $550 per month in income (about 40% of the federal poverty level) cannot qualify for Texas Medicaid, even though the children do. In addition, because Medically Needy coverage no longer exists, the parents are responsible for catastrophic costs relating to any injury. Under Texas law, parents do not qualify for Medicaid unless they are disabled or until they lose their jobs dropping them below current income limits for Medicaid coverage.

Dunkelberg (2005) explains:

> Since parents can qualify for Medicaid and appear on the rolls in several categories—Temporary Assistance for Needy Families recipients, Medically Needy/Section 1931, or Transitional Medicaid—it is easiest to combine these groups and look at how the total has changed. In July 2003 . . . 147,217 parents with dependent children were covered under Texas Medicaid (not including maternity coverage), and as of May 2005 that number had dropped to 100,518, a drop of 46,699 (32%). (p.1)

The number of low-income uninsured parents continues to rise in Bexar County. This, coupled with the elimination of the Medical Needy program for parents and the choice by the Texas legislature not to increase the Temporary Assistance for Needy Families federal poverty level limit, has decreased the number of Bexar County working poor parents that are eligible for Medicaid. The ability to increase medical financial coverage for this population while concurrently reducing county healthcare costs is an ongoing challenge for University Health System.

Evidence

Any change in Medicaid eligibility in Bexar County will have a causal effect on many organizations and individuals. An expansive literature review and explanation of the current healthcare landscape in Texas in regards to poverty and the uninsured, Medicaid and its use in Texas, the Bexar County Healthcare system and various existing components that include CareLink, Community First Health Plans and Metro Public Health Department is provided to enhance the base knowledge of the policy reviewer if required. The discussion of current issues will begin at a global level within Texas and narrow the focus to the Bexar County healthcare system.

Poverty in Texas

Poverty in Texas is another factor synonymous with being uninsured. Adults with children represent 26% or 3.4M of the population that currently live in poverty; 18%, 1.5 million adults with no children are also living in poverty. The average percent federal poverty level for adults with children in the United States is 19% and 15% for adults with no children (Kaiser Family Foundation, 2005b). Approximately 44% of the Texas population was living below 200% of the federal poverty level from 2003-2004 compared to 36% of the nation (Table 1).

Table 1

Texas: Distribution of Total Population by Federal Poverty Level, States (2003-2004)

	TX #	TX %	US #	US %
Under 100%	4,996,940	23	50,481,410	17
100-199%	4,633,180	21	54,647,220	19
Low Income Subtotal	9,630,110	44	105,128,620	36
200% +	12,420,090	56	185,157,720	64
Total	22,050,200	100	290,286,350	100

Note. Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2004 and 2005 Current Population Survey (CPS: Annual Social and Economic Supplements).

Most poor families with children in Texas are working families. Of the 513,000 families with children below poverty, 81% (415,000) are headed by a full time or part time worker. A family is "worker-headed" if either the head-of-household or spouse worked at some point during the year (Strayhorn, 2005). On average, these families worked 45 weeks per year. Approximately 1.7 million people, 943,000 of whom are children, live in these working-poor families. Almost half of these families, 48%, include a full-time, year-round worker. Of the

689,000 families with incomes between 100% and 200% of the poverty level, 80%—551,200—are headed by a worker. These families include 2.2 million Texans, 1.1 million of whom are children (Kluever, 2005).

The 2004 U.S. Census estimated there where 1.5 million people and approximately 513, 000 households in Bexar County in which 15% of all families and 37% of families with a female householder with no husband present had incomes below the federal poverty level (Table 2).

Table 2

Percentage Estimate Of 2004 Bexar County Families And People Whose Income In The Past 12 Months Is Below The Poverty Level

	Estimate	Lower Bound	Upper Bound
All families	14.6	12.1	17.1
With related children under 18 years	22	18.1	25.9
With related children under 5 years only	24.1	15.4	32.8
Married couple families	8.4	6.3	10.5
With related children under 18 years	13	9.6	16.4
With related children under 5 years only	19.1	9.9	28.3
Female householder, no husband present	36.8	29.7	43.9
With related children under 18 years	44.9	36.4	53.4
With related children under 5 years only	38.5	20.3	56.7

Note. U.S. Census, American Community Survey, 2005.

The U.S Census also estimated that approximately 228,704 households in Bexar County have family incomes that fell below 200% federal poverty level, which is $38,700 for a family of

four (U.S. Census, American Community Survey, 2005). The low socioeconomic status of many Bexar County residents is a continuing obstacle for local healthcare providers. Concomitantly local lawmakers are challenged by the increasing number of uninsured within the county and the state due to the low socioeconomic conditions of many residents.

Uninsured in Texas

Coverage gaps and lack of health insurance for low income parents have been studied extensively over the past five years and is still a relevant issue within Texas and the United States (Lambrew, 2001; Dubay & Kenney, 2001b;Gayer & Mann, 2003; Currie & Gruber, 2001; Kenney, Haley, & Blumberg, 2002; Davidoff, Dubay, Kenney, & Yemane, 2003). It is important to look at these issues and their prevalence in the state of Texas. As discussed by Thorpe (1998), lack of health insurance tends to be a shared family problem. Parents who regularly access healthcare are more apt to ensure their children have the same access. The same is true of parents who do not have recurrent access to healthcare services and the effect it has on children's health. According to the Acs & Nichols (2005), health problems are more prevalent among low-income working families due to lack of insurance coverage; 16% of fulltime workers heading low-income families report fair or poor health compared to 7% of middle income families. Collins, Doty, and Davis (2004) reported (Figure 1) the affordability of healthcare insurance correlates with access and medical care decisions made by patients.

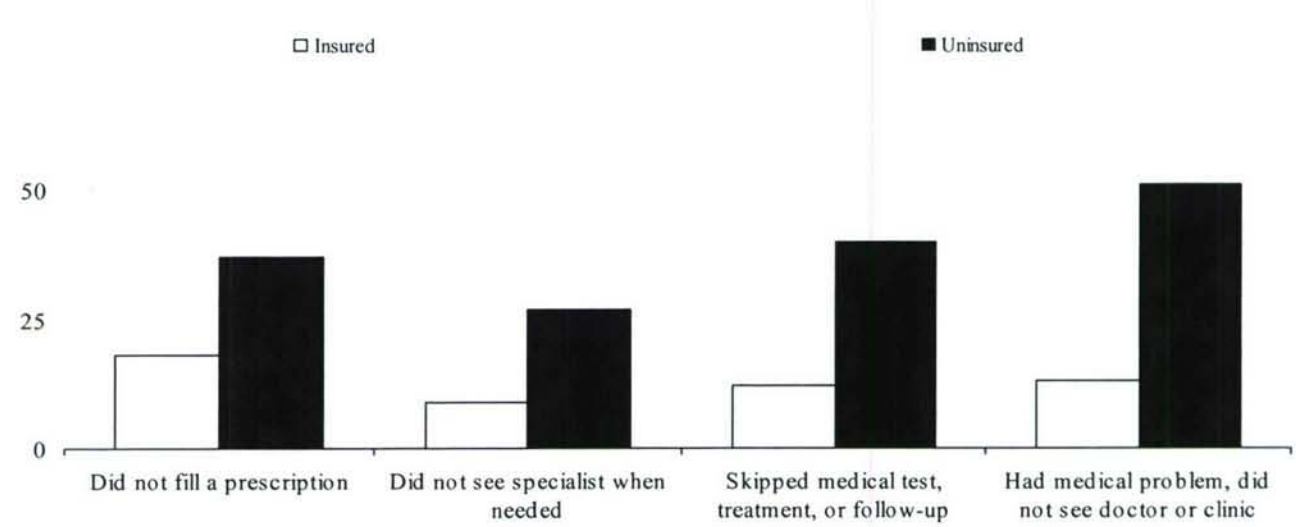


Figure 1. Gaps in Insurance Coverage Hinder Access to Care, The Affordability Crisis in U.S. Health Care: Findings From The Commonwealth Fund Biennial Health Insurance Survey, The Commonwealth Fund, 2004.

Dubay and Keeney (2001b) found that uninsurance rates have been rising for low-income parents below the federal poverty level. Dubay and Keeney (2001b) also indicated that Medicaid could greatly reduce the uninsurance rate among parents and increase their access to care. They wrote,

> Without Medicaid expansions it is unlikely that parents living in poverty will gain health insurance coverage. Moreover, since few poor parents (21% in 2000) have employer-sponsored coverage, there is limited potential for expansion in Medicaid to crowd out employer-sponsored coverage among poor parents. (p.233)

The idea that Medicaid expansion has minimal effects on private insurance crowd out has been empirically studied and documented by Shore-Sheppard (2005), Currie (1999), and Cutler and Gruber (1996). Cutler and Gruber (1996) estimated that approximately 50% of the increase

in Medicaid coverage for pregnant women and children from 1987-1992 was associated with a reduction in private insurance coverage availability. In summary, it is difficult to crowd out employer sponsored insurance if it is decreasing independently of changes in Medicaid coverage.

Increases in health insurance expansion, public or private, may also lead to better health outcomes. Dafney and Gruber (2000) found,

> . . . by assessing the impact of the Medicaid expansions over the 1983-1996 period on the incidence of avoidable hospitalizations. We find that expanded public insurance eligibility leads to a significant decline in avoidable hospitalization: over this period Medicaid eligibility expansions were associated with a 22% decline in avoidable hospitalization. (p.1)

In other words, any increase in healthcare access through Medicaid will reduce avoidable hospitalizations and increase healthcare utilization in primary care and preventative services.

As reported by the Institute of Medicine (IOM) in 2004, every year approximately 18,000 deaths of people between the ages of 18-64 are attributed to the lack of health insurance (IOM, 2004). The U.S. Census (March 2004) survey reports that an average of about 5.4 million Texans, or 24.6% of the state's population, were uninsured (U.S. Census Bureau, Table HI-06, 2004). In Texas, from 2001 to 2004, an average of 59% of the uninsured population had an income below 200% of the federal poverty level (U.S. Census Bureau, Table HI-04, 2004). In 2005, 200% of the federal poverty level was $19,140 for one person and $32,180 for a family of three; 250% was $23,925 for one person and $40,225 for a family of three (Department of Health and Human Services, 2003).

Based on the Texas State Comptroller analysis of the 2004 Census data, Laredo, Brownsville, and El Paso had the highest rates of uninsured—one in three residents of these

cities lacked private health insurance (Strayhorn, 2005). This data also shows that an estimated 15.6% of the U.S. population, or 44.9 million people, lacked health insurance at some point. "In Texas during the same period, about 5.4 million people went without health insurance coverage making Texas the state with the largest share of uninsured in the U.S." (p.1) according to Carole Strayhorn, Texas Comptroller of Public Accounts. According to the U.S. Census Bureau in 2004 Bexar County had approximately 372,000 or 24.3% county residents uninsured (69% Hispanics, 25% White, non-Hispanics, 3.4% African Americans, 2.4% Asians 0.2% Native Americans).

Texas workers are also less likely to have employment-based health insurance (ESI) coverage than workers are in other states. In 2003, Texas ranked 48th in the nation, with only 52.4% of Texans having employment-based health insurance coverage (U.S. Census HI-04, 2004). From 2000 to 2004, ESI decreased by 5.5% in Texas and 4.9% nationally (Table 3), highlighting a nationwide trend.

Table 3

Texas: Percentage Point Change Among Non-elderly by Coverage Type, 2000-2004

	TX %	US %
Employer-Sponsored Insurance	-5.5	-4.9
Individual Insurance	-0.5	0.3
Medicaid	3.2	2.7
Uninsured	2.2	1.7

Note. Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2004 and 2005 Current Population Survey (CPS: Annual Social and Economic Supplements).

The Texas Department of Insurance has identified trends that may explain Texas' lower rate of ESI. The Texas Department of Insurance notes that Texans are more likely to work in

service industries that are less likely to offer health insurance. In addition, the Texas Department of Insurance has found that most insurers and employers in the state have provisions that exclude part-time, contract, and seasonal workers from health coverage (Strayhorn, 2005). Texas county hospitals continue to carry the burden of paying for the healthcare of full-time low income uninsured adults with children due to a lack of ESI combined with the second highest state cost of uncompensated care in the nation, approximately $4.6B dollars in 2005.

In 2001, a small business survey, developed by the Texas Department of Insurance using the State Planning Grant, was mailed to 50,000 small employers to collect information on their attitudes and perceptions regarding health insurance and their ability and willingness to purchase private coverage. A follow-on survey was mailed to small business employers in March 2004 to evaluate the effectiveness of previous state efforts to increase access to health insurance for business and identify new issues that may have emerged. The companies responding to the 2004 survey had an average of 10.4 total employees, with 8.5 full-time employees 1.9 part-time employees (Texas Department of Insurance, 2005). The Texas Small Employer Health Insurance Survey Results (2001-2004) published in November 2005, had some significant findings:

- The primary reason employers do not offer insurance is that it is unaffordable; 54% of employers reported they can afford $100 a month or less per employee for health insurance premiums; 34% can pay $50 or less, and 14% would not purchase insurance at any cost.
- 81% of employers believe employers *should* provide insurance if they can afford to do so. In a separate question, however, only 7% indicated they believe employers are *primarily* responsible for assuring people have coverage; 41% believe individuals are

themselves responsible; 32% said the federal government is responsible, and 12% believe state governments are responsible.

- Of those employers who currently offer insurance, 18% are very likely to discontinue coverage within the next five years; 24% report they are somewhat likely to do so.
- 69% of employers said it is more important for government to focus on improving access to affordable health insurance than improving access to affordable health care, while 26% said that improving access to affordable health care is more important.
- When small businesses do offer coverage, employees often are unable to afford their required contribution. This is particularly true of family coverage. Workers in small businesses often must pay a higher share of the premium cost than workers in large firms. The average cost of family coverage for small businesses is more than $11,000 a year per-employee, and many workers must pay 50% or more of the cost. For low wageworkers, this expense is truly unaffordable. A significant decrease in cost would be necessary in order for many of these workers to take up the health insurance that is available to them.

Knowing the issues that currently drive small employers away from providing health insurance coverage provides a road map, which policy makers can use to expand coverage to the uninsured low-income working adults with children. The issues defined by small business employers outlined in the survey are related to the structure of health care delivery within the state and have a direct influence on how local healthcare providers respond to healthcare needs.

Healthcare Structure in Texas

To view the landscape in which the issue of uninsured low-income parents propagates, understanding the history of the Texas healthcare system and the lines of responsibility for

providing healthcare is necessary. Texas counties are primarily the budgeting bedrock for the safety net in Texas. Counties have a statutory responsibility under state law to provide health care to the indigent (Texas Health and Safety Code, Chapter 61). Counties can fulfill this responsibility by administering a public hospital, developing a hospital district, or managing a county indigent health care program.

Vernon's Texas Civil Statutes were the first state statutes that outlined the counties' responsibility for providing indigent care. For example, century-old Texas' laws required each county to provide for the support of residents in their county, who were unable to support themselves (Fenz, 2000). Texas courts interpreted this requirement to include medical care despite the lack of any statutory guidelines to define exactly whom the county was responsible for and exactly what healthcare services they were required to provide. Further complicating the issue was the existence of different healthcare benefit standards for counties with public hospitals and hospital districts. The lack of standardization led the governor to act in 1983 and establish a task force to evaluate the system and make recommendations for improving access to care for the indigent population (Fenz, 2000).

The recommendations from the two-year task force resulted in the Indigent Health Care and Treatment Act (IHCTA) of 1985, which clearly defined the county's responsibility to provide health care to the indigent. In an effort to further delineate the indigent population from the general population, the IHCTA defined *indigent* in terms of income and assets (Fenz, 2000). The act made individual counties solely responsible for providing health care to people whose incomes were less than 17 % of the federal poverty level (Texas Health and Safety Code, Chapter 61, Sec. 61.006).

The Texas County Indigent Health Care program (CICHP) is a state program requiring counties with an excess of 190,000 residents to create countywide hospital districts that assume responsibility for providing medical and hospital care to needy residents. Through state law, hospital districts, like Bexar County, are granted local property taxing authority, which serves as the primary funding source for indigent care programs. Each hospital district's County Commissioner Court, an elected body of local officials, determines the actual funding level obtained through the property tax. Hospital districts have significant latitude in defining eligibility standards and scope of services, but they cannot establish income and resource eligibility standards that are more restrictive than set out by the Texas Department of Health, which is currently 17% federal poverty level (Fenz, 2000). The eligibility standards defined by each county directly related to the standards set for Medicaid eligibility by the state because the counties will utilize state Medicaid programs whenever possible to offset local program costs.

Medicaid

Medicaid, operating as 51 individual programs, is the country's largest health care program. As of 2005, Medicaid covered approximately 53 million people, accounting for one of every six dollars spent on personal healthcare in the U.S. and half of the national spending on long-term care. Medicaid spending continues to accelerate at double-digit rates to over $300B, threatening the states' ability to afford expanding coverage to existing groups (Kaiser Family Foundation, 2005a). Rising annual costs continue to hamper state budget policy decisions making it increasingly difficult for legislatures to propose expansion in coverage.

Federal laws passed in the late 1980s mandated Medicaid coverage for groups of people ineligible for Temporary Assistance for Needy Families or Supplemental Security Income resulting in a major expansion of the eligible population and exponential increase in the cost of

Medicaid. Members of working families and others with low incomes are now also eligible to receive Medicaid (Social Security Online, 2005). The Social Security Act of 1965 set out the following fundamental principles and requirements for each state's Medicaid program:

1. State wideness: All Medicaid services must be available on a statewide basis and may not be restricted to residents of particular localities unless authorized by a Medicaid waiver.
2. Comparability: Except where federal Medicaid law specifically creates an exception, the same level of services (amount, duration, and scope) must be available to all patients.
3. Freedom of Choice: Clients must be allowed to go to any Medicaid health care provider who meets federal and state program standards.
4. Amount, Duration, & Scope: States must cover each service in an amount, duration, and scope that is "reasonably sufficient." States may impose limits on services only for Medicaid clients who are age 21 and over (Centers for Medicare and Medicaid Services [CMMS], 2005).

These terms and conditions also specify that a state Medicaid program must cover certain mandatory eligibility groups and mandatory benefits. The state must also meet other requirements that relate to the use of managed care, qualifications of providers, and beneficiary cost sharing. Federal law specifies that a state be entitled to federal Medicaid matching funds when it provides qualifying groups and benefits that are listed as mandatory or optional. Altogether, there are 28 categories of Medicaid eligibility in federal law. Mandatory population groups that a state must cover in its Medicaid program include individuals that meet defined criteria in specific populations groups including: (1) low income families with children (2) elderly (3) blind and disabled persons receiving SSI cash assistance (4) infants born to Medicaid

eligible women through their first year of life (5) children under the age of 6 and pregnant woman whose family income is at or below 133% of the federal poverty level (CMMS, 2005).

States must offer a specified set of mandatory medical services to these identified groups. Services include pregnancy-related services, home health care, nursing home services for adults, inpatient and outpatient hospital care, physician services, family planning, medically necessary services identified through periodic well-child exams, laboratory, and x-ray services. States also have the option to receive federal Medicaid matching funds for up to 38 optional services, which may include dentists, optometrists, podiatrists, therapists, ambulance transports, eyeglasses, hearing aids, medical equipment and supplies, and prescription drugs. Because most of these services are very costly when offered, states use broad discretion in deciding the scope and duration of the coverage. Historically states have looked at optional coverage and services as the first place to reduce adult Medicaid costs (CMMS, 2005).

The federal government does not, and states cannot, limit the number of eligible people who can enroll for Medicaid (Appendix A). Medicaid must pay for any services covered under the program if state residents are eligible, thus making it an entitlement. States must provide medically necessary care to all eligible individuals who seek services. The Secretary of the U.S. Department of Health and Human Services determines each state's federal matching rate of most health care costs (federal medical assistance percentage - FMAP) using a formula based on average state per capita income compared to the U.S. average (Texas Department of Health Services, 2005). Current law dictates that the maximum federal rate is 83% and the minimum is 50%. Texas' matching rate for federal fiscal year 2005 is 60.87%; the state must pay 39.13% of most Medicaid costs (Department of Health and Human Services, 2003).

States may use local county funding for up to 60% of the state's matching rate. Texas uses local county funding for the upper payment limit reimbursement program, the disproportionate share hospital, and other aspects of the Medicaid program in order to increase federal matching funds. The disproportionate share program provides reimbursement to hospitals that serve a disproportionately large number of Medicaid patients or other low-income people to help compensate them for lost revenues. The upper payment limit (UPL) is a program that reimburses hospitals for the difference between what Medicaid pays for a service and what Medicare would have paid for it. Medicaid cannot pay more than Medicare would have paid for a service, and Medicare rates are generally higher, so this difference is called the *Medicaid upper payment limit.*

Texas officials use the federal poverty level guidelines to determine eligibility for most state public benefits, including Medicaid, food stamps, the Children's Health Insurance Program (CHIP), childcare subsidies, and Temporary Assistance for Needy Families. Income limits vary greatly by program, ranging from less than 15% of the federal poverty level (federal poverty level) for Temporary Assistance for Needy Families to 200% of federal poverty level for CHIP. The federal government establishes income limits for predetermined benefits, such as food stamps and other nutrition programs, while states have flexibility in setting eligibility limits for others, such as CHIP and Temporary Assistance for Needy Families. In some programs, like Medicaid, the income limits vary according to the age of the recipient. Eligibility for public assistance programs in Texas (Table 4) is very restrictive compared to other states, the benefits are lower, and health benefits for poor adults are more limited. As a result, a smaller share of the poor in Texas receives any public assistance.

Table 4

Examples of Top Percent of Poverty Income Limits Associated with Selected Health and Human Service programs (Texas-specific)

Federal Poverty Level	Program
14%	Upper limit for parents of children in Temporary Assistance for Needy Families program.
17%	Upper limit for children in Temporary Assistance for Needy Families program.
21%	Upper limit for Medically Needy program under Medicaid (applies to pregnant women and children only).
74%	Upper limit for Medicaid / SSI (excluding the Medicaid Long-Term Care disabled).
100%	Upper limit for Medicaid children ages 6 through 18 (excluding the Medicaid Long Term Care disabled).
130%	Upper limit for the Food Stamps program (and based on household, not family income).
133%	Upper limit for Medicaid children ages 1 through 5 (excluding the Medicaid Long-Term Care disabled).
150%	Upper limit for state-subsidized child care for children under age 13.
158%	Top limit for pregnant women (19 years and older) under Medicaid.
185%	(A) Upper limits for infants under age 1 under Medicaid; (B) Upper limit for pregnant women (Under 19 years of age) under Medicaid; (C) Women and children in the Women, Infants, and Children Program (WIC).
200%	Upper limit for Children Health Insurance Program (CHIP). Applies to children under 19 who would otherwise be uninsured and who are not income-eligible for Medicaid.
220%	Upper limit for Medicaid long-term care (all ages).

Note. Research and Evaluation Department Texas Health and Human Services Commission Updated 7/29/2005.

Several options are available for states to provide health insurance to parents with children eligible for Medicaid. Options include traditional Medicaid, exclusively state or county funded programs, and state Medicaid Section 1115 waiver initiatives, which are often used in conjunction with state-funded programs. Few states have extended coverage to parents with

children on Medicaid through CHIP. Medicaid and state-funded programs to insure adults have been in existence for years, of note Section 1931 of the Social Security Act, which considerably increases states' ability to extend Medicaid coverage to both parents and children in low-income families. States also use Section 1115, Section 1931 and CHIP funding authorities to construct new designs to cover adults (Krebs-Carter & Holahan, 2000).

Medicaid Waivers:

Waivers allow the U.S. Department of Health and Human Services to waive certain Medicaid laws and regulations to give states increased program flexibility and to encourage experimentation with new approaches to delivering services. There are two broad waiver types. Section 1115 waivers called *research and demonstration waivers* usually involve comprehensive reform projects and test innovative healthcare policy initiatives, while Section 1915 waivers are called *program waivers* and involve waiving specific requirements to allow more innovative programs such as managed care and community-based care.

Federal rules require that 1115 waivers meet budget neutrality requirements and last no more than five years without being renewed. For a demonstration to be budget neutral, it must not cost more than the Medicaid program would have cost over the course of its duration based on Medicaid law at the time it was approved (CMMS, 2005). Section 1115 waiver authority can be used to expand Medicaid to include nondisabled adults with and without children, institute a managed care plan for various populations as Florida did in 2005 (Centers for Medicaid Studies, 2005), and to waive financing rules. As of January 2006, 40 of the 50 states, including the District of Columbia, currently have active 1115 waivers to expand care under Medicaid. Texas currently has five 1915(b) (Freedom of Choice) and seven 1915(c) (Home and Community

Based Services) waivers, and no approved 1115 waiver (CMMS, 2005). More information on Medicaid Waiver requirements can be found in Appendix B.

Medicaid Section 1931: Family Coverage

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 reformed the welfare system and *delinked* cash assistance and Medicaid eligibility determinations, creating a category of individuals eligible only for Medicaid. This category gives states flexibility to establish more liberal eligibility rules and income limits to provide Medicaid coverage to families who are eligible for Temporary Assistance for Needy Families.

Income and Asset Disregards

States can use less restrictive standards for counting income and resources in determining Medicaid eligibility, as long as a state's rules for determining countable income do not cause anyone who would otherwise be eligible to lose coverage. States can disregard earnings or assets of families without limit and without any need for a waiver from Centers for Medicare and Medicaid Services when determining eligibility (Guyer & Mann, 1998).

2005-2006 Federal and State Medicaid Changes

2006 Federal Budget Medicaid items approved.

Though spending for these programs will continue to grow, federal spending will be reduced by a net $39B during the five-year period FY 2006-2010. Some changes affecting the Medicaid program include:

- Medicaid Reductions: gross savings of $11.6 billion over five years; net savings of $4.8B
- Savings of $3.9B in prescription drugs savings
- Savings of $2.4B from revised asset rules for persons seeking long-term care assistance, primarily from increasing the look back period from three to five years

- Savings of $3.2B from authorizing states to increase cost sharing and premiums. Reduces costs to state and federal government by reducing non-emergency use of emergency department visits, encouraging use of generic drugs, cost sharing with beneficiaries, and development of plans for some beneficiaries with less extensive benefit coverage
- Limits the expansion of SCHIP programs to cover non-pregnant childless adults (benefiting from the enhanced federal funds matching rate) to those waivers approved before October 1, 2005
- Funding levels for the basic Temporary Assistance for Needy Families grants to states are maintained at the current $16.5B annual level through FY 2010; however, the $319M annual supplemental grants to states are extended only through 2008. Texas receives $52M annually in supplemental grants
- Work participation rates are maintained at 50%, but are also applied to separate state programs. The caseload reduction credit is revised with a base year of 2005 rather than 1996. Penalties are created if states do not establish and maintain work verification procedures (Texas Office of State-Federal Relations, 2005).

Texas Medicaid expansions and restorations signed by Governor Rick Perry during the 2005 79th Legislative Session.

Governor Rick Perry signed Senate Bill 747, which proposes to use a Medicaid 1115 Waiver to expand eligibility for women's health. The proposed program will expand eligibility to women ages 18 and older whose family incomes are at or below 185% of the poverty level. Currently, Medicaid beneficiaries are not eligible for preventive health care and family planning services if their incomes are at or above 17% of the federal poverty level. Services covered under the plan would include regular screenings for cervical and breast cancers, sexually transmitted

diseases, hypertension, cholesterol and tuberculosis. Under the measure, women also would have access to contraception (Texas Senate Bill 747, 79th Texas Legislature, 2005).

Because of Senate Bill 1, several benefits have been restored for clients 21 years of age and older and will be reimbursable by the Texas Medicaid Program. Benefits include services provided by a chiropractor, services provided by a podiatrist, eyeglasses, and contact lenses (when medically necessary), and hearing aid instruments and related services. Governor Perry also signed Senate Bill 566 creating a Medicaid buy-in program for employed persons with disabilities whose current income disqualifies them for Medicaid (Texas Senate Bill 1 and 566, 79th Texas Legislature, 2005).

Waivers submitted prior to 2005 legislative session under review.

Currently there are three 1115 waivers for city-level demonstration projects authorized by House Bill 3122 of the 78th Legislature that have not been formally submitted to CMMS as of December 2005. General outlines of these waivers were submitted for preliminary review, and CMMS responded that more discussion would be needed on the proposals, especially on the subject of limited enrollment options (Warner, Jahnke, & Kimble, 2005). These waivers propose to use the additional federal dollars that the local match would obtain to fund local programs to cover uninsured low-income parents not currently eligible for other programs.

The proposed Austin/Travis County waiver intends to expand designated Medicaid services to optional Temporary Assistance for Needy Families adults (non-disabled, 18-64) or adults with dependent children. This waiver would include coverage of residents living in Travis County with incomes between 17%-100% federal poverty level. Budget neutrality is to be achieved through savings from implementing a reduced benefit package, and by providing a

medical home, pharmaceutical management, and reduced emergency department visits (Warner, Jahnke, & Kimble, 2005).

The Bexar County Hospital District waiver would involve a Medicaid expansion for adult health care services to needy parents (aged 21 to 64) of children on Medicaid. The goal is to promote independence from welfare by providing a health care safety net for working poor between 14.4% and 100% federal poverty level. The waiver proposes the use of an existing Medicaid HMO with no employer involvement. The waiver would seek to waive state wideness, freedom of choice, and cost sharing. Budget neutrality is expected to be met through savings achieved by providing services through a medical home and using continuous eligibility versus the existing Medicaid program (Warner, Jahnke, & Kimble, 2005).

The El Paso County Hospital District Waiver would expand Medicaid coverage to Temporary Assistance for Needy Families and SCHIP adults (21 to 64 years) between 14.4% and 200% federal poverty level. The waiver would also restore the medically needy program for this area, and may try to expand coverage to a select number of childless adults (ages 21-64) (Warner, Jahnke, & Kimble, 2005).

Bexar County Healthcare System

The Bexar County Hospital District d/b/a University Health System does business under the authority of section 1115(a) of the 1965 Social Security Act. University Health System is a hospital district established under Article IX, Section 4 of the Texas Constitution and Chapter 281 of the Texas Health and Safety Code. Recognized as the political subdivision for the State of Texas, University Health System provides hospital and medical care to the indigent and needy population of Bexar County. The staff of University Health System University Hospital operates San Antonio's only civilian level one trauma center, University Center for Community Health,

and four outpatient community health centers. The system includes a 604 licensed bed hospital, five clinic locations providing primary and specialty care, and a managed care plan. In addition, University Health System holds a contract with the University of Texas Health Sciences Center to provide physicians to staff its facilities. Annually, University Health System provides staff for 18,541 inpatient days and manages roughly 160,000 outpatient lives per year, with 60% of its patient mix being uninsured (University Health System, 2005).

University Health System has expanded healthcare coverage throughout the county with partnerships that involve Federally Qualified Health Centers (FQHC), Metro Health (Public Health Department), and various smaller organizations. These ever-blossoming relationships are pivotal to successfully meeting the mission of providing care for the uninsured and indigent population of Bexar County, which is in large part accomplished through the Care*Link* program.

CareLink

The Care*Link* Program is a health care payment plan, which provides financial assistance with health care expenses to uninsured residents of Bexar County, Texas. The program is sponsored by the University Health System. Implemented in 1997, Care*Link* currently serves nearly 61,000 individuals, the bulk of who have incomes below 150% of the federal poverty level. Members can receive primary and preventive services at 21 different locations around San Antonio County to include all FQHCs. Inpatient and specialty services are offered at University Hospital. While not an insurance plan, several features of the Care*Link* program are modeled on managed care concepts. For example, participants are assigned to a primary care provider and make monthly payments, primary and preventative care are emphasized, and Care*Link* set out a defined schedule of benefits that are monitored by a gatekeeper (J. Simmons personal communication, July 2005).

Bexar County is committed to providing health care to uninsured residents, as University Health System's mission is to provide services to both *indigent* and *needy* residents, defined as those residents falling at or below 75% federal poverty level and those falling between 76% and 185% federal poverty level, respectively. Care*Link* does allow families over 185% of federal poverty level to participate; however, they must make substantially higher payments and use electronic check debits for their monthly payments. In 2006, a new program modeled after CareLink will be available to Bexar County residents whose income falls below 300% of the federal poverty level.

While county property tax dollars provide University Health System funding to help pay for care to the uninsured, patients are also expected to contribute. University Health System wanted to improve the patient contribution rate and in the early 1990s began exploring ways to determine an individual's ability to pay what they could afford rather than imposing a flat percentage of the bill. As a further effort to encourage patients to pay part of the bill, it was decided to spread payments over time like a car or house payment rather than requiring one lump sum payment (J. Simmons, personal communication, July 2005). Eventually University Health System officials developed a formula to assign patients a maximum family liability (MFL): MFL = (11%) (Annual family income) (2005 federal poverty level index). The MFL is then broken down into monthly installments over a 48-month period. If a patient's expenses exceeded their maximum liability fee, the remainder of the costs would be absorbed by the University Health System's budget for indigent care. An example of average monthly payments for a family of four at the various poverty levels is shown in Figure 2 below and is based on the 2005 Care*Link* financial guidelines outlined in Appendix C. Membership in Care*Link* is one year, except for those with fixed incomes who are granted two-year membership. Members receive notification

in the mail 90, 60, and 30 days prior to their re-determination date. Once a member incurs a charge, their account balance will be their maximum family liability or actual charges, whichever is less.

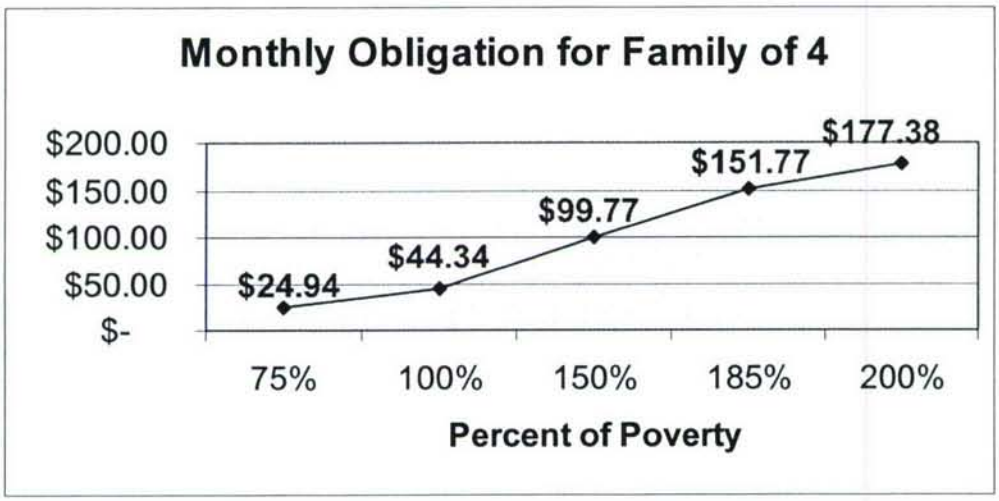


Figure 2. CareLink Monthly Obligation

Uninsured persons are not required to participate in Care*Link* to receive services at University Health System. However, for those uninsured persons who do not participate, only emergency care services and emergency inpatient care are provided unless they pay for the services in advance. This falls within Emergency Medical Treatment and Active Labor Act requirements and regulations. For the Care*Link* member, a health care structure and support mechanism is offered for the first time to many patients. For example, they are assigned a primary care physician, can make appointments, and are encouraged to use preventive care. There is support staff in each one of the University Health System clinics versed in the CareLink program to assist current and future members.

Most families using this program are located in the Southern part of Bexar County (Appendix D) (J. Simmons, personal communication, July 2005). To be eligible for Care*Link*, individuals must be residents of Bexar County. Residency is defined as having a home in the

county and the intent to stay. There is no income eligibility requirement, as those with higher incomes are just required to pay larger portions of their medical bills. As shown in Table 3, most of the 60,333 current members are low-income residents, with only a small percentage (5.4%) earning more than 185% federal poverty level as shown in Table 5.

Table 5

CareLink Demographics, December, 2005

Gender	Percentage
Female	59.1
Male	40.9
Age Group	Percentage
0-18	8.7
19-29	15.3
30-39	16.4
40-54	31
55-64	20.1
65- Over	8.4
Federal Poverty Levels (federal poverty level)	Percentage
≤75%	27.8
76-150%	57.6
151-185%	9.2
≥ 186%	5.4
Federal Poverty Levels (federal poverty level)	Average Age
≤75%	40.6
76-150%	43.1
≥ 151%	45.6
Ethnicity Percentage	
Asian 0.7% Black 5.1%	Hispanic 76.2 White 13.8%
American Indian 0.0% Other 1.7%	Unknown 0.1 Field Blank 2.4%

Note. Care*Link* Director provided date.

The Care*Link* application process includes screening for other state and federal health benefit programs for which individuals may be eligible for benefits. If someone in the household

is eligible for Medicaid or Children Health Insurance Program (CHIP), a 60-day enrollment into Care*Link* is granted during which their application for Medicaid and/or CHIP will have been screened and accepted, or disapproved. If a child is found eligible and the parents fail to apply within the 60-day window, the family is disqualified from Care*Link*. Care*Link* is always the payer of last resort when other programs can be used first. University Health System administrators and the Board of Managers believe that children should not be denied medical care if the parents fail to enroll them in the proper program. Therefore, children in these families will continue to have access to services but the parents will be billed full charges and normal collection policies are followed (J. Simmons, personal communication, July 2005).

Care*Link* benefits were designed to include a comprehensive array of primary, preventive, specialty, and inpatient services that match the current Medicaid schedule of benefits. Among other things, Care*Link* participants can purchase at a discounted rate preventive care services, family planning, primary and specialty care, drugs, and mental health services. Care*Link* administrators actively manage the schedule of benefits in Table 6 to ensure the best standard of care. CareLink staff manages and monitors the pharmacy drug usage rates and identify ways to control costs in the formulary. The staff has also proactively been signing up participants for the new Medicare Part D program for the past year (J. Simmons, personal communication, July 2005).

Table 6

Schedule of Benefits. CareLink program University Health System

Preventive care well child care, physical exams, mammography
Physician services primary and specialty care
Family planning sterilization and birth control
Medical services and supplies
Radiation therapy, chemotherapy, allergy testing and serum, x-rays and lab testing, dialysis, oxygen, lab services, x-rays
Hospital inpatient all inpatient covered services and supplies, intensive care unit stays, physician charges
Outpatient services clinic visits and outpatient surgery
Health education nutritional/dietetic counseling
Mental health services inpatient facility and service charges, day treatment facility, outpatient visits for intervention and evaluation
Emergency room physician services and supplies
Pharmacy approved list of medications with some restrictions

Note. Information provide by Director Care*Link, 2006.*

Another benefit of Care*Link* is that it helps manage and control costs of caring for the uninsured. By imposing some structure and utilization review, costs can be tracked better. Likewise, by improving access to preventative care and providing a primary care provider to the uninsured, costs are contained. Another factor is the Care*Link* population is a group whose insurance status changes with some frequency. Sometimes they have insurance and sometimes they do not, due to the changes in Medicaid since 2003. Care*Link* affords University Health

System the opportunity to establish a medical relationship and primary care home with program participants so once private insurance is procured they will continue to come to University Health System rather than go elsewhere (J. Simmons, personal communication, July 2005). However, the program does have some problems with adverse selection that are associated with socioeconomic induced health problems.

Other organizations that assist in the provision of healthcare to low income families are Community First Health Plans, Center for Health Care Services, Metro Health San Antonio Public Health Department and other large health systems in Bexar County, and Federally Qualified health Centers.

Community First Health Plans and Center for Health Care Services

Community First Health Plans, the region's only locally owned and operated, not-for-profit HMO, was established in 1995, and is a key part of University Health System. The Center for Health Care Services provides a comprehensive array of mental health, mental retardation, and drug and alcohol abuse services that serve the needs of the county's mentally ill or mentally retarded residents.

Other Large Health Systems in Bexar County

Other large health care providers in Bexar County that receive DSH funding to serve the indigent population include Christus Santa Rosa, Baptist Healthcare System, and Methodist Healthcare. These providers are not part of the Care*Link* network but may still see Care*Link* patients per the request of University Health System. For example, certain pediatric specialties are seen at Christus Santa Rosa Children's Hospital when the service cannot be provided by University Health System.

Metro Health San Antonio Public Health Department

The San Antonio Metropolitan Health District is the single public agency charged with the responsibility for public health programs in San Antonio and unincorporated areas of Bexar County. Although the Health District is a city/county organization, administrative control is under the City of San Antonio and the District is operated as a city department. Health District services include preventive health services, health code enforcement, clinical services, environmental monitoring, animal care, disease control, health education, dental health, and maintenance of birth and death certificates (F. Guerra, Director of Public Health, personal communication, February, 2006).

The Metropolitan Health District is presently organized into four service components for control and coordination of activities and 24 locations throughout the city. An administrator who oversees activities and answers to the Director of Health manages each component. These four service components are: 1) Administrative and Support Services, 2) Food and Environmental Health Services, 3) Personal/Family Health Services, and 4) Special Operations & Dental Services (F. Guerra, Director of Public Health, personal communication, February, 2006).

Federally Qualified Health Centers

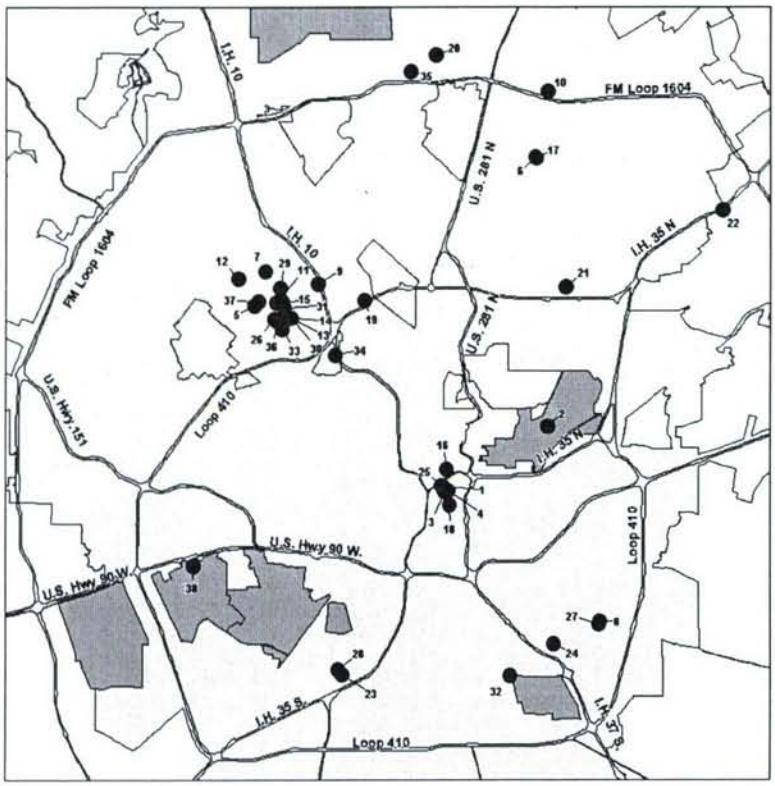
Bexar County, identified as a Medically Underserved Area (MUA), opened the Barrio Comprehensive Family Health Care Center in 1972 and El Centro Del Barrio in 1973 to meet the growing demand of the indigent population. Medically Underserved Areas (MUA) are areas in which residents have inadequate access to personal health services based on physician access, percentage of aged population, poverty rates, and health status indicators. Using these factors, an index of medically underserved is created and a national average is obtained. If an area is below the national index average of 162, it is identified as an MUA. As of January 2006, 177 of 254

Texas counties are classified as medically underserved. Bexar County and 47 other counties are classified as partially underserved (Texas Department Health State Services, 2006). There are 11 FQHC locations throughout Bexar County in which to receive care.

Issue for discussion

San Antonio offers a variety of hospital based care (Figure 3) throughout Bexar County in which low-income uninsured parents can receive quality patient centered care. This has been documented in the recent Urgent Matters (2005) report completed by the Robert Wood Johnson Foundation.

> The demand for safety net services in Bexar County is expected to grow due to general increases in the population as well as growth in the number of individuals who are employed but uninsured. Reductions in Medicaid and CHIP eligibility and benefits are likely to adversely affect access to needed services . . . Many safety net providers struggle to maintain levels of care in the midst of shrinking support from the county for care of the uninsured . . . any additional cuts would further weaken an already fragile and fragmented system of care. (p.3)



1 Baptist Medical Center
2 Brooke Army Medical Center
3 CHRISTUS Santa Rosa Children's Hospital
4 CHRISTUS Santa Rosa City Centre
5 Christus Santa Rosa Medical Center
6 Compass Hospital of San Antonio
7 HEALTHSOUTH RIOSA
8 Innova Hospital of San Antonio
9 Kindred Hospital San Antonio
10 Laurel Ridge Treatment Center
11 LifeCare Hospitals of San Antonio
12 Methodist Ambulatory Surgery Hospital
13 Methodist Children's Hospital
14 Methodist Hospital
15 Methodist Specialty & Transplant Hospital
16 Metropolitan Methodist Hospital
17 Mission Vista Behavioral Health System
18 Nix Health Care System
19 Nix Specialty Health Center
20 North Central Baptist Hospital
21 Northeast Baptist Hospital
22 Northeast Methodist Hospital
23 Promise Hospital
24 San Antonio State Hospital
25 Select Specialty Hospital-San Antonio, Inc.
26 South Texas Veterans Health Care System
27 Southeast Baptist Hospital
28 Southwest General Hospital
29 Southwest Mental Health Center
30 Southwest Texas Methodist Hospital
31 St. Luke's Baptist Hospital
32 Texas Center for Infectious Disease
33 Texas Specialty Hospital at San Antonio
34 TexSan Heart Hospital
35 The Spine Hospital of South Texas
36 University Health System
37 Warm Springs Rehabilitation Hospital
38 Wilford Hall Medical Center

Figure 3. Bexar County Hospital Locations.

In order to increase access to care often an increase in spending of some sort to offset the costs is required. Increasing Medicaid coverage for the working uninsured parents of Medicaid eligible children has many challenges. Any potential alternatives must improve the overall health status of Bexar County residents and continue to keep the county health system financially stable. The next section will present alternatives Bexar County can utilize to expand the use of Medicaid within the county.

Alternatives

Alternative one - Medicaid 1115 Health Insurance Flexibility and Accountability (HIFA) Waiver.

Under the authority of section 1115 of the Social Security Act, a five-year Medicaid research and demonstration waiver could be used to extend access to Medicaid for parents of Medicaid children. The demonstration would be called *Cost sharing for certain optional Medicaid groups*. The target population in Bexar County would be an adult with dependent children in his/her household whose income ranges from 17% -200% of the federal poverty level. Increasing the Temporary Assistance for Needy Families federal poverty level limit to 200% in Bexar County in order to receive federal matching funds would be required. The 1115 waiver is different from the 2003 Bexar County proposed waiver request because it involves local employers in the financing of a portion of the premiums.

Bexar County's HIFA demonstration would cover uninsured parents of Medicaid and SCHIP children, in a partnership with employers in the county. Those eligible for coverage would include uninsured parents of Medicaid and SCHIP children, who are themselves ineligible for Medicaid under the State's current Temporary Assistance for Needy Families limits, with incomes up to 200% of the federal poverty level. The county requests the state use county revenue from the indigent care fund as state general revenue to retain federal matching funds for the coverage of this "optional population". The county revenue and federal match would be transferred through an intergovernmental transfer back to University Health System. The demonstration will be limited to 3000 adults for the first year. Follow on year expansions will be based on continuing to achieve budget neutrality.

The Bexar County approach to coordination between public and not for profit insurance, which is a requirement of the HIFA initiative, is unique. Ordinarily, coordination takes the form

of providing premium assistance for existing employer-sponsored insurance to enable low-income uninsured individuals to purchase insurance. Bexar County's approach differs from that model in that the county will create new employer-sponsored insurance through the existing Community First Health Plan because few ESI options currently exist in Bexar County. The county will contract Community First Health Plan to provide a new insurance product for employers to offer to their low-income workers similar to the model of Care*Link*. The policy would be purchased with a combination of county, federal matching funds, employer, and employee contributions.

For those individuals with an income up to 100% of federal poverty level ($19,350 for a family of four), no premiums would be required. According to the 2004 U.S. Census American Community Survey, there are a projected 42,000 families in Bexar County whose income is below 100% federal poverty level. For all participants, there are co-payments of $5 to $20 for the most frequently used primary care services, similar to many currently available commercial insurance plans. Out-of-pocket charges for all participants would be limited to 5% of family income. This plan is a compilation of various state plans that have already been accepted by CMMS and implemented within the U.S.

Providing the employer with an incentive to provide this new insurance product is perhaps the key to success. Options that exist for enticement include county and state tax credits for covered lives, reimbursement of premiums if certain threshold of care is not reached by participants, and free coverage of employer's family members. The waiver presents the possibility of shifting current Care*Link* adults with children over to the insured option that fall under the 200% federal poverty level limit and work for employers who sign up.

Alternative 2 - Local Hospital District funding of Medically Needy Program

The 79th Texas Legislature proposed a partial reactivation of the Medically Needy Program for adults to increase coverage to the uninsured population at or below the 200% federal poverty level. Funding for this reactivation would come solely from the five Texas hospital districts. This funding would be deemed state general revenue and be used to retain federal matching funds and redistributed to all Texas counties through intergovernmental transfers. According to Dunkelberg (2005), "HHSC estimated that full restoration of Medically Needy would cost $175M general revenue for 2006-2007" (p. 5). In contrast, Senate Bill 1 authorizes just $35M for partial restoration of the program for parents.

Alternative 3 – Education

Increase Medicaid education, in particular the existing federal and state assistance programs, through a local grocery chain to target population. Use of a frequently visited area for goods and services will increase exposure to information about federal and state programs. Kenney et al. (2001) found that 44% of parents have heard of Medicaid or SCHIP but do not understand that their families do not need to participate in welfare for them or their children to be eligible. More than half of all low-income parents either are not aware of any child health insurance program in their state or do not know that enrollment in welfare is not a precondition for participation. Many low-income Americans are eligible for existing government programs, such as Medicaid, CHIP, and Care*Link*, but may not know that they are eligible or may have chosen not to enroll. In the U.S., one-third of the uninsured are eligible for government-sponsored programs, but have not enrolled in them (Blue Cross Blue Shield Association, 2005). This alternative involves a large local business and would require buy in from their Board of Directors in order to be successful.

Alternative 4 - Status Quo

To maintain status quo, University Health System would not address the issue of uninsured working poor parents with Medicaid eligible children.

Criteria for Evaluation of Alternatives

The selected criteria are not used to judge the alternatives directly. The criteria are used to evaluate the projected outcomes that are the derivatives of the alternatives (Bardach, 2005). The criteria used to evaluate the alternatives in expanding the use of Medicaid in Bexar County by University Health System will be effectiveness, cost, and access (Tables 7, 8, & 9). Using these three measures will allow for a broad evaluation that should encapsulate the necessary thought provoking exercises required to complete a thorough policy analysis.

Effectiveness

Effectiveness is defined as, "the degree to which improvements in health now attainable are, in fact, attained. Effectiveness outcomes concern the results achieved in the actual practice of healthcare with typical patients and provider, in contrast to efficacy, which is assessed by the benefits achieved under ideal conditions" (Aday, Begley, Lairson, Balkrishnan, 2004, p. 57). A macro view, or population perspective, considers the role of social, physical, and economic environments, and the health of the population. This view includes the evaluation of both the people who are currently receiving medical care and the people in the population. Conceptual frameworks that have forwarded effectiveness research are contained in works by Evans, Barer, and Marmor (1994) from a population perspective and Donabedian (2003) from a clinical perspective (Aday et al., 2004).

The use of a population strategy to improve the structure is present in the United States when one examines the *Healthy People* Report and the establishment of the Office of Health Promotion and Disease Prevention. The *Healthy People 1990* objectives evolved into the *Healthy People 2010* objectives. This policy strategy controlled the focus of the U.S efforts on population health for 20 years. Other examples of a population perspective of improving health lie in various federal programs that include the National Institutes of Health, Hill-Burton Act, Health Professions Educational Assistance, and Comprehensive Health Planning (Aday et al., 2004). Effectiveness can be broken into three areas of structure, process, and outcomes. All areas of medical care should be measured, monitored, benchmarked, and improved (Donabedian, 2003). Structure, process and outcome are linked conceptually as the three basic elements that can be empirically evaluated in healthcare. Structure refers to ". . . the conditions under which care is provided. These include: (1) material resources, such as facilities and equipment; (2) human resources, such as the number, variety, and qualifications of professional and support personnel; (3) organizational characteristics, such as the organization of the medical and nursing staffs, the presence of teaching and research functions, kinds of supervisions and performance review" (Donabedian, 2003, p. 46).

Process refers to ". . . activities that constitute health care – including diagnosis treatment, rehabilitation, prevention, and patient education – usually carried out by professional personnel, but also including other contributions to care, particularly by patients and their families" (Donabedian, 2003, p. 46). Evaluating process using a population perspective would require the researcher to look at utilization rates or realized access for the target population in a target area (Aday et al., 2004).

Donabedian (2003) wrote that outcomes,

> . . . mean changes in individuals and populations that can be attributed to health care. Outcomes include (1) changes in health status (2) changes in knowledge acquired by patients and family members that may influence future health care (3) changes in behavior of patients or family members that may influence future health (4) satisfaction of patients and their family members with the care received and its outcomes" (pp. 46-47).

Examples from a population perspective may include the use of overall population mortality, morbidity rates, or health status.

Cost

Controlling costs is also one of the major challenges to implementing any expansion of healthcare coverage. Growth in health care spending is attributed to increases in the costs of hospital care, prescription drugs, technology, and long-term care. In 2004 spending on health care accounted for nearly 15% of the countries economy. Expenditures in the United States on health care were nearly $1.7T in 2003, almost 2 and a half times the $696B spent in 1990, and almost 7 times the $246B spent in 1980 (2003 National Health Care Expenditures, 2004). These costs affect individuals and businesses. Since 2000, employer-sponsored health coverage premiums have increased by 73% (Kaiser Foundation, 2005b). Employers are increasingly shifting costs to their employees in the form of higher premiums, deductibles, and co-payments. With workers' wages growing at a much slower pace than health care costs, many face difficulty in affording this growth in out-of-pocket spending. According to the Kaiser Foundation (2005b), "In 2004, annual premiums for employer-sponsored health coverage averaged $9,950 for family

coverage and $3,695 for individuals" (p. 1). Premiums for family coverage has increased nearly 60% since 2001, rising at a far faster rate than worker salaries (Gabel et al., 2005).

Medicare and Medicaid program spending continue to rise, but at a slower rate than private employer plan premiums. Medicare spending is likely to increase as the new prescription costs are realized. Medicaid spending comprises one of the largest items in state budgets, and many states report cuts in eligibility or benefits to reduce the costs. Ongoing Medicaid cuts make cost a true detractor to any expansion to current Medicaid programs.

Access

Conclusions about access to care outcomes rely heavily on what data are used and what questions are asked. Some measures focus on the availability of care and disregard the ability to pay for that care as being a roadblock to access. Other measures focus on the provider's willingness to see a certain type of patient based on the type of reimbursement. Simple areas to evaluate on a local level when looking at access to care can be: 1) the capacity of the health system to meet the needs of the target population, 2) the availability and willingness of providers to see the target population, 3) and the ability of the patient to pay the providers and the health system.

Other measures used on a state and national level come from the National Quality Measures Clearinghouse. There is a myriad of measures which include components of quality medical care (effective, safe, timely, patient centered, equitable and efficient) to the priority populations specified by Congress in the Healthcare Research and Quality Act of 1999, which are low income groups, minority groups, women, children, elderly and individuals with special healthcare needs. In 2003 and 2004, the Agency for Healthcare Quality and Research released the National Healthcare Disparities Report, which focuses on disparities in health care among

racial, ethnic, and socioeconomic groups in the general U.S. population and among priority populations.

Criteria for Matrix

Effectiveness

Change in Individual Health Status. The Bexar County Population Health Benchmarks that mirror Health People 2010 measures will be used as a measure of improvement with any new program expansion. They consist of prostate cancer death, breast cancer death, lung cancer death, cerebrovascular diseases, diabetes, cancer deaths, heart disease deaths, and suicide deaths.

Preventative Services Availability. The program selected should increase the availability of preventative services to the target population.

Cost

Costs to the individual. The program selected should only nominally change the cost to the individual.

Cost to the federal government. The program selected should be budget neutral and will not increase the total amount the Federal Government would pay that is required by law as of 2006.

Cost to state government. The program selected should reduce the costs of uncompensated care to the State.

Cost to county taxpayers. The program selected should not increase taxes more than is politically acceptable as comparable to other large health systems in Texas.

Cost to the county government. The program selected should not adversely place at risk the current positive fiscal position of the county hospital system and the county.

Cost to employers. The program selected should reduce the overall healthcare cost to county employers.

Access

Health insurance availability. Health insurance helps people get into the health care system. The program selected should increase overall affordable access to health insurance without crowding out current available local products.

Specific source for ongoing care after initial primary care visit. Having a usual source of care helps people get into the health care system, yet over 40 million Americans do not have a specific source of ongoing care (Healthy People 2010, 2002). Alternative will provide a primary and secondary source of care that will improve the continuity of care.

Health care utilization rates. Besides access to care, health care utilization is strongly affected by health care need and patient preferences and values. In addition, greater use of services does not necessarily indicate better care. In fact, high use of some inpatient services may reflect impaired access to outpatient services. The alternative will increase the use of preventative and diagnostic services to decrease the early onset of chronic illness.

Projection of Alternative Outcomes

Medicaid 1115 Health Insurance Flexibility and Accountability Waiver

Establishing an 1115 Medicaid waiver to offer an insurance product to uninsured low-income parents with Medicaid eligible children would not be a new concept in the United States and within the Medicaid program. Currently, Minnesota and New Jersey offer similar programs to expand care to uninsured parents of Medicaid eligible children. Using this option would assist in the financial support of the current expansion of health insurance availability through Care*Link* to the target population. The waiver would allow University Health System to continue providing a specific source for beneficiaries after the initial primary care visit and will presumably increase healthcare utilization rates. Increasing the use of the healthcare product will

also lead to moderate increase in costs for the target population due to the premium share and co-pays. However, co-pays will not exist for those under the 100% federal poverty level the annual share of the premium will. Cost will increase for the federal government but could be budget neutral.

The guidelines from CMMS (2005) indicate the HIFA demonstration project is a venue for states to explore methods to use current level Medicaid and SCHIP resources to increase health insurance options within their state. Any HIFA waiver or component of a HIFA waiver funded with State Children's Health Insurance Program (SCHIP) funds must be neutral to the allotment of SCHIP funds for that state. The federal cost of a HIFA waiver using SCHIP funds may not exceed a state's SCHIP allotments for the demonstration period and any carry forward of prior SCHIP allotments. States may not presume redistribution of SCHIP funds in building these budgets. Without actuarial projections, it is difficult to confirm the validity of budget neutrality in this alternative.

State costs will not increase because the county is providing the revenue to receive the match from the federal government to utilize the waiver. The county, in turn, may see a minimal increase due to the increasing number of uninsured regardless of whether the waiver is approved. The increase in cost rolls down to the Bexar county taxpayers. Bexar County has not seen a tax increase request from University Health System to cover the costs of indigent care since 2001.

The greatest benefactor, besides the healthcare recipient, may in fact be the employer when looking at cost. The employer will now have a quality low cost health insurance option to offer the employees that will provide a primary care manager and follow up medical care. Medicaid expansion through this waiver may reduce time employees spend in the emergency department for non-urgent healthcare issues and increase the overall health of employees. When

compared to their insured counterparts, uninsured low-income parents were more likely to have a fair or poor health status and have unmet medical needs. They were less likely to have had a doctor or professional health visit (Holohan, 2000). This also speaks to the effectiveness of this alternative. An added benefit is the effect it may have on the family. If an adult is more likely to utilize the health care system because of being insured, then the children should also benefit through higher utilization of the health care system (Hanson, 1998).

Though effective, it may increase the possibility of crowding out other local insurers in Bexar County that focus on the target population. As required by Medicaid a constant monitoring of insurance companies and trends will need to be performed in order to identify negative affects of any waiver. The Texas Department of Insurance survey pointed out the one of the biggest detractors for small business in taking up health insurance for employees is the increasing cost of premiums. A majority of Texas employers, 81%, believed that employers should provide insurance if they can afford to do so. Only 7% believed that employers are primarily responsible for providing that (Texas Department of Insurance, 2005).

Local Hospital District funding of Medically Needy Program to receive Federal Match.

Reinstating the Medically Needy program would increase health insurance availability for the target population when presented with catastrophic medical bills. It would allow for limited access during a defined period to the Medicaid program for parents. It would not however increase the likelihood of having ongoing specific source of care after the initial primary care visit. The program is meant to be a form of short-term public assistance for residents that have become overwhelmed by medical bills stemming from ongoing chronic medical problems.

Costs for the individual will decrease during the time of Medicaid coverage but will increase for the federal government and the county based on the nature of the proposal. The state will not incur any added cost because they are not financing any part of the program and they are not providing any general revenue to attain the federal match. Employers will see no change in cost unless the county raises taxes to pay for the program. The same is true for county taxpayers. The ability to receive Medicaid reimbursement for this population could lead to a reduction in cost for University Health System for the target population.

The program, originally available to adults prior to the 2003 cuts, was very effective in filling the gap created by excessive medical bills. Individual health status will improve but at varying degrees depending upon the illness and the term of coverage that is needed. The increased likelihood of seeing a physician for medical problems would moderately increase due to the eligibility of ongoing access to Medicaid providers within the county. Preventative services would increase for many in this population only for the time in which they are eligible for Medicaid.

Education

Education is perhaps the easiest way in which to expand Medicaid coverage for low-income parents that may already be eligible for public assistance. Using a large local grocery chain as an education center is not a new tool. Charity organizations like the Red Cross and Salvation Army have successfully been using this concept for many years. It also serves as a great public relations tool for that organization highlighting its concern for the health of the general population in Bexar County.

When looking at access measures, education increases the perception of availability through the knowledge of its existence. Eligibility does not actually increase because the newly

informed patient was already eligible they just did not know they where. The newly acquired knowledge does not guarantee use of the healthcare system. If enrolled in Medicaid, there will be a specific source of care and an increase in health care utilization rates. Any increase in access is based on the client's use of the benefit for which they are eligible.

The cost for education is minimal across all payer categories except at the county level. To expand Medicaid education efforts at local grocery store sites money will be needed for any employee salaries and educational materials. These costs would be marginal when compared to the overall cost of providing uncompensated care throughout the county. The program would also be effective in changing health status, improving provider communication because of the availability of a primary care manager, and increasing preventative services availability to those individuals that are eligible for Medicaid. The effectiveness of this alternative is severely restricted by the Medicaid eligibility standards within the state.

Table 7.

Evaluation options for increasing access to care for uninsured low-income parents of Medicaid eligible children.

	Access		
Policy Options	Health Insurance Availability	Specific Source for Ongoing Care After Initial PC Visit	Health Care Utilization Rates
Medicaid 1115 HIFA Waiver	(+) Great Increase	(+) Great Increase	Moderate Increase
Local Hospital District funding of Medically Needy Program to receive Federal Match.	Moderate Increase due to program time limits.	No change (-)	Minimal Increase (-)
Increase education efforts through Metro Health and local grocery chain	Minimal Increase. Education does not guarantee use. (-)	Moderate increase if citizen eligible for Medicaid.	Great Increase if citizen eligible for Medicaid (+)

Note. This is compared to the status quo. (+) indicates most favorable effect and (-) indicates most unfavorable effect.

Table 8.

Evaluation options for providing low-cost access to care for the uninsured low-income parents of Medicaid eligible children compares to the status quo.

	Cost by Payer					
Policy Options	Individual (>17% and </=200% federal poverty level)	Federal Government	State Government	County Government/ University Health System	County tax payers	Employer
Medicaid 1115 HIFA Waiver	Moderate Increase for share of premiums and co pays required to take part in program. (-)	Moderate Increase due to Federal Matching funds already required per Medicaid laws. (-)	No Change (+)	Minimal Increase (+)	Minimal Increase (-)	Minimal Increase but may be offset by County tax credit. (-)
Local Hospital District funding of Medically Needy Program to receive Federal Match.	Minimal Decrease due to program benefits time limits.	Moderate Increase due to Federal Matching funds already required per Medicaid laws. (-)	No change based on legislative proposal.	Moderate Increase (-)	Minimal Increase	No Change.
Increase education efforts through Metro Health and local grocery chain	No change (+)	Minimal increases from increased case load and take up rates. (+)	Minimal increase from increased case loads and take up rates. (-)	Minimal Increase	No Change. (+)	Decrease (+)

Note. (+) indicates most favorable effect and (-) indicates most unfavorable effect.

Table 9.

Evaluation options for providing effective access to care for the uninsured low-income parents of Medicaid eligible children compares to the status quo.

Policy Options	Effectiveness	
	Change in Individual Health Status	Preventive Services Availability
Medicaid 1115 HIFA Waiver	Great Increase (+)	Great Increase based on schedule of benefits. (+)
Local Hospital District funding of Medically Needy Program to receive Federal Match.	Minimal Increase due to patients already being seen regardless of payer.	No Change. (-)
Increase education efforts through Metro Health and local grocery chain	Minimal Increase. Education does not guarantee use. (-)	Moderate Increase if citizens are eligible for public assistance.

Note. (+) indicates most favorable effect and (-) indicates most unfavorable effect.

Analysis of Trade-offs

Sometimes one of the policy alternatives under consideration is expected to produce a better outcome than any of the other alternatives, referred to as dominance (Bardach, 2005). The following analysis will compare and contrast the three different alternatives relative to the status quo in effectiveness, access, and cost. A trade-off typically occurs at the margin. How much of "X" are we willing to give up to attain "Y.?" In other words, how much money are we willing to pay to increase access to Medicaid for the uninsured adults with children? Looking at the issue without a political or social emphasis, the response to the issue often comes down to how much it will cost to fix the problem.

The Medically Needy program is at best a temporary fix for a growing problem. Though temporary, it would still provide increased access and be effective for a limited time. The greatest detractor to this proposal is the cost to the large county hospitals and the idea of

relinquishing funds to the state for the federal match with no specific net gain. Patients are not required to go to any specified facility for medical care. The counties would be required to fund the entire state Medically Needy program for public and private hospitals. According to Dunkelberg (2005), "HHSC estimated that full restoration of the Medically Needy program would cost $175M GR for 2006-2007. In contrast, SB1 authorizes just $35M for "partial restoration" of the program for parents" (p.5.). Hospitals are not enthusiastic about establishing a precedent in which the prior year state Medicaid cuts will only be reversed if local governments provide the revenue for the federal match.

Utilizing increased education efforts is the least expensive option to initiate and will have an immediate effect on the local population. Many may not know they are eligible for public assistance because information is not available to them. Not knowing about eligibility is good and bad, depending on the perspective. It is good for any government trying to reduce healthcare spending costs by delaying caseloads and the cost of providing care for these individuals until they are seen in an emergency room and or admitted to a facility. It is bad for the individual who might have attempted to seek care earlier for the chronic condition had he known he was covered by Medicaid. This alternative is the quickest solution to a growing problem.

The use of an 1115 Medicaid waiver brings with it an array of issues that must be considered. The waiver alternative offers the greatest way in which to increase access to and improve the effectiveness of the healthcare system in the county. It also offers a way to increase matching funds from the federal government already available to the state that are currently not being used by the state. A waiver offers local business owners who employ many of the below 200 % federal poverty level family members a means in which to offer affordable health coverage through a local health maintenance organization. The Texas Department of Insurance

small business survey suggested if small businesses are offered an affordable means in which to provide coverage they are willing to do it (Texas Department of Insurance, 2005). The same businesses said they would like a tax credit for the premiums they pay on behalf of their employees. The county would need to look at local tax laws to evaluate if it is possible.

A negative effect of a local county waiver is the potential for crowd-out within the county of local insurance companies and the potential for increased resident migration to the Bexar county area. If the county offers a plan that no other county in the state offers, then residents may move to the area just for the healthcare coverage. This effect has already taken place on a small level with the CareLink indigent care program. University Health System and Community First Health Plans (CFHP) would have to monitor new resident take up rates. Cost of the waiver is interesting because the proposed population is already covered by the CareLink program and county tax dollars. The advantage of using a Medicaid waiver to cover this population is the provision of a federal match to cover the expense born by University Health System and CFHP.

Recommendations

The goal of this policy analysis is to define alternatives in which the University Health System can pursue to continue to offer healthcare coverage to parents of Medicaid eligible children using Medicaid financing. Medicaid is a complex program with varying levels of eligibility based on geographic location and economic status. Federal and state pressure to reduce Medicaid funding at all levels makes any expansion difficult to attain. The development of an 1115 waiver to expand health insurance to low-income parents, would meet the needs of the county. The use of the waiver would bring much-needed federal matching funds to the Bexar county health district and defray some of the burden that has been assumed by the local taxpayers. If approved, the waiver is the most effective long term alternative in expanding coverage to the target population while concurrently reducing the cost for Bexar county residents.

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Appendix A: Eligibility for Medicaid Programs

States have some discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. To be eligible for Federal funds, States are required to provide Medicaid coverage for most individuals who receive federally assisted income maintenance payments, as well as for related groups not receiving cash payments. Some examples of the mandatory Medicaid eligibility groups are contained in Table A1 below:

Table A1. *Medicaid Eligibility Groups (CMMS 2005)retrieved from www.cms.hhs.gov/MedicaidEligibility/03_MandatoryEligibilityGroups.asp*
Low-income families with children, as described in Section 1931 of the Social Security Act, who meet certain of the eligibility requirements in the State's Temporary Assistance for Needy Families plan in effect on July 16, 1996.
Supplemental Security Income (SSI) recipients (or in States using more restrictive criteria--aged, blind, and disabled individuals who meet criteria which are more restrictive than those of the SSI program and which were in place in the State's approved Medicaid plan as of January 1, 1972).
Infants born to Medicaid-eligible pregnant women.
Children under age 6 and pregnant women whose family income is at or below 133 % of the Federal poverty level. (The minimum mandatory income level for pregnant women and infants in certain States may be higher than 133 %, if as of certain dates the State had established a higher %age for covering those groups.) States are required to extend Medicaid eligibility until age 19 to all children born after September 30, 1983(or such earlier date as the State may choose) in families with incomes at or below the Federal poverty level. This phases in coverage, so that by the year 2002, all poor children under age 19 will be covered. Once eligibility is established, pregnant women remain eligible for Medicaid through the end of the calendar month in which the 60th day after the end of the pregnancy falls, regardless of any change in family income. States are not required to have a resource test for these poverty level related groups. However, any resource test imposed can be no more restrictive than that of the Temporary Assistance for Needy Families program for infants and children and the SSI program for pregnant women.
Recipients of adoption assistance and foster care under Title IV-E of the Social Security Act.
Special protected groups who may keep Medicaid for a period.

States also have the option to provide Medicaid coverage for other "categorically needy" groups. These optional groups share characteristics of the mandatory groups, but the eligibility criteria are somewhat more liberally defined. Examples of the optional groups that States may cover as categorically needy (and for which they will receive Federal matching funds) under the Medicaid program are contained in Table A2:

Table A2. *Medicaid Categorically Needy groups (CMMS 2005)* *Retrieved from www.cms.hhs.gov/MedicaidEligibility/04_OptionalEligibility.asp*
Infants up to age one and pregnant women not covered under the mandatory rules whose family income is below 185% of the Federal poverty level (the percentage to be set by each State).
Optional targeted low-income children.
Certain aged, blind, or disabled adults who have incomes above those requiring mandatory coverage, but below the Federal poverty level.
Children under age 21 who meet income and resources requirements for Temporary Assistance for Needy Families, but who otherwise are not eligible for Temporary Assistance for Needy Families.
Institutionalized individuals with income and resources below specified limits.
Persons who would be eligible if institutionalized but are receiving care under home and community-based services waivers.
Recipients of State supplementary payments.
TB-infected persons who would be financially eligible for Medicaid at the SSI level (only for TB-related ambulatory services and TB drugs).
Low-income, uninsured women screened and diagnosed through a Center's for Disease Control and Prevention's Breast and Cervical Cancer Early Detection Program and determined to be in need of treatment for breast or cervical cancer.

Appendix B: Types of Medicaid Waivers

Table B.

Common Types of Federal Medicaid Waivers, table retrieved from Texas Medicaid in Perspective, Fifth Edition, 2004 pgs 3.12-3.13.

Waiver	Description
Research and Demonstration 1115 waivers	**PURPOSE** • Allow flexibility for states to test new ideas for operating their Medicaid programs. Waives a variety of requirements, such as comparability or state wideness. **STATES HAVE USED THESE WAIVERS TO** • Structure statewide health system reforms. • Test the value of access to new services or service delivery mechanisms. • Maximize coverage of health insurance for people below 200 % of federal poverty level. • Extend drug coverage to certain low-income non-Medicaid elderly and disabled individuals. **REQUIREMENTS** • Must be budget neutral for the duration of the waiver. Budget neutral means the Federal Government will not being paying more than it normally would if these groups where covered. **TIMEFRAME** • 5-year waivers, subject to renewal. • CMMS analyzes impact on utilization, insurance coverage, public and private expenditures, quality, access, and satisfaction.
Freedom of Choice 1915(b) waivers	**PURPOSE:** • Allow states to waive state wideness, comparability of services and freedom of choice. States can mandate Medicaid enrollment into managed care, use a "central enrollment broker" to assist people in making health plan choices, use cost savings to provide additional services, and/or limit the number of providers for clients. An example would be Community First Health Plan in San Antonio managing special needs populations. **STATES MAY USE TO:** • Limit clients' choice of Medicaid providers. • Require Medicaid clients to join managed care organizations in order to receive Medicaid services. • Provide an enhanced benefit package with cost savings from managed care. • Selectively contract with hospitals and other types of health care providers to increase cost-effectiveness and to better control quality of services. **REQUIREMENTS:**

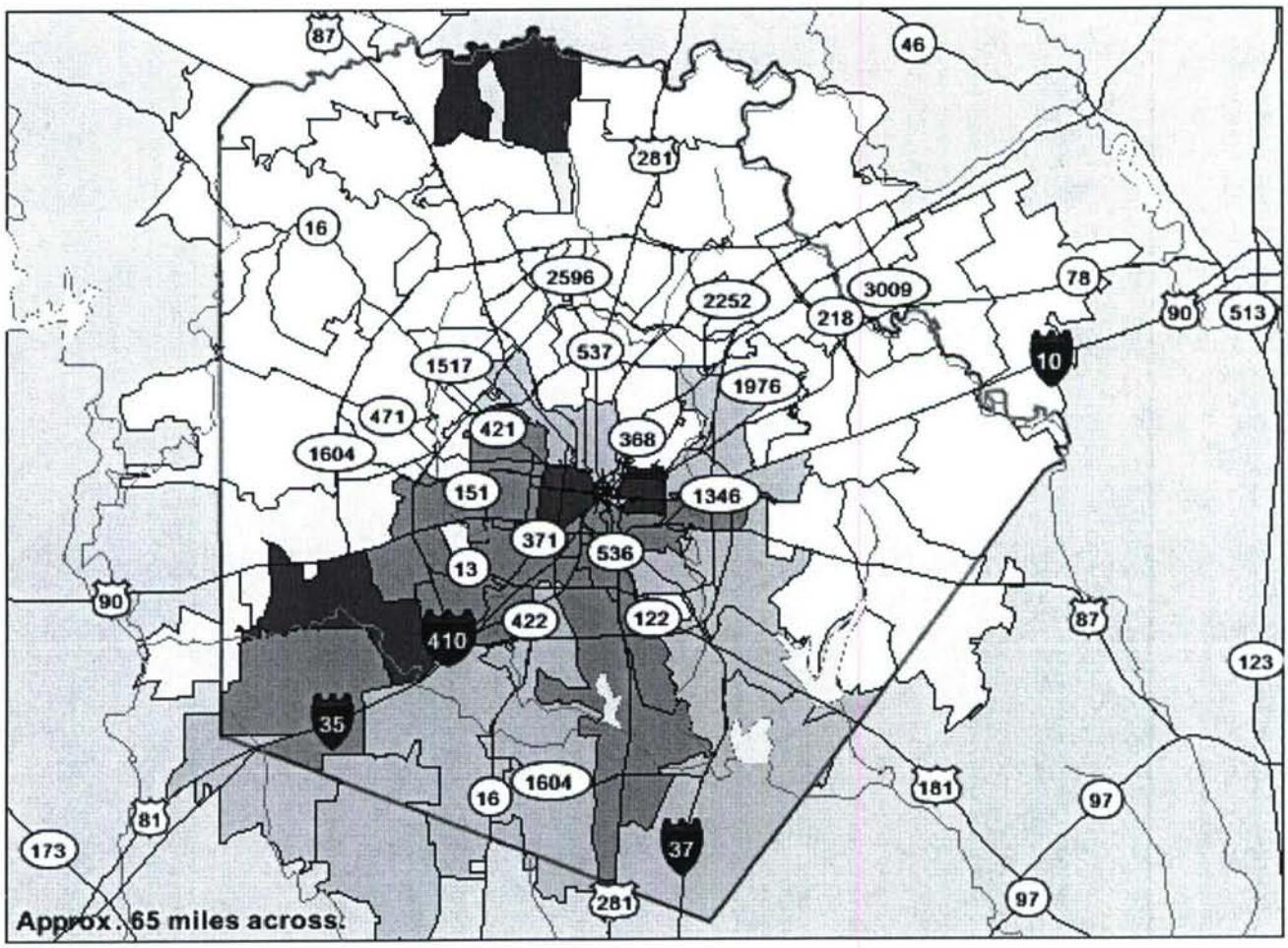
	• Must be cost effective. • Must measure for improvements. • Client access, quality of care and cost must not be negatively impacted by implementation of waiver. **TIMEFRAME:** • 2-year waivers, subject to renewal. • CMMS requires an independent assessment to show that cost, quality, and access have not been compromised.
Home and Community-Based Services 1915(c) waivers	**PURPOSE:** • Allow states to provide community-based services to people who meet eligibility criteria for care in an institution (nursing home, intermediate care facilities for persons with mental retardation, or hospital) or who would otherwise meet eligibility criteria for care. **STATES MAY USE TO:** • Serve elderly persons or persons with physical and/or developmental disabilities, mental retardation or mental illness. States may also target more specialized populations such as clients with traumatic brain injuries or those with developmental disability and sensory impairment. • Develop community-based treatment alternatives to institutional care in hospitals, nursing facilities or intermediate care facilities for persons with mental retardation (ICFs/MR). • Provide services which are not found in the state plan or which extend state plan services. Examples include case management, homemaker/home health aide services, personal care services, adult day health, and habilitation, and respite care, non-medical transportation, in home support services, special communication services, minor home modifications, and adult day care. **REQUIREMENTS:** • Must be budget neutral for the duration of the waiver. • Must assure safeguards are in place to protect clients. **TIMEFRAME:** • Initially approved for 3 years and may be renewed at 5-year intervals.

Appendix C: CareLink Financial Obligation

UNIVERSITY HEALTH SYSTEM
CareLink Financial Obligation

	FAMILY SIZE							
	1	2	3	4	5	6	7	8
ANNUAL	2005 POVERTY GUIDELINES							
INCOME	$ 9,570.00	$ 12,830.00	$ 16,090.00	$ 19,350.00	$ 22,610.00	$ 25,870.00	$ 29,130.00	$ 32,390.00
$ 1,000.00	$ 0.24	$ 0.18	$ 0.14	$ 0.12	$ 0.10	$ 0.09	$ 0.08	$ 0.07
$ 2,000.00	$ 0.96	$ 0.71	$ 0.57	$ 0.47	$ 0.41	$ 0.35	$ 0.31	$ 0.28
$ 3,000.00	$ 2.16	$ 1.61	$ 1.28	$ 1.07	$ 0.91	$ 0.80	$ 0.71	$ 0.64
$ 4,000.00	$ 3.83	$ 2.86	$ 2.28	$ 1.89	$ 1.62	$ 1.42	$ 1.26	$ 1.13
$ 5,000.00	$ 5.99	$ 4.47	$ 3.56	$ 2.96	$ 2.53	$ 2.21	$ 1.97	$ 1.77
$ 6,000.00	$ 8.62	$ 6.43	$ 5.13	$ 4.26	$ 3.65	$ 3.19	$ 2.83	$ 2.55
$ 6,645.00	$ 10.57	$ 7.89	$ 6.29	$ 5.23	$ 4.48	$ 3.91	$ 3.47	$ 3.12
$ 7,178.00	$ 12.34	$ 9.20	$ 7.34	$ 6.10	$ 5.22	$ 4.56	$ 4.05	$ 3.65
$ 7,500.00	$ 13.47	$ 10.05	$ 8.01	$ 6.66	$ 5.70	$ 4.98	$ 4.43	$ 3.98
$ 8,000.00	$ 15.33	$ 11.43	$ 9.12	$ 7.58	$ 6.49	$ 5.67	$ 5.03	$ 4.53
$ 9,000.00	$ 19.40	$ 14.47	$ 11.54	$ 9.59	$ 8.21	$ 7.18	$ 6.37	$ 5.73
$ 9,623.00	$ 22.17	$ 16.54	$ 13.19	$ 10.97	$ 9.39	$ 8.20	$ 7.29	$ 6.55
$ 10,000.00	$ 23.95	$ 17.86	$ 14.24	$ 11.84	$ 10.14	$ 8.86	$ 7.87	$ 7.08
$ 10,500.00	$ 26.40	$ 19.69	$ 15.70	$ 13.06	$ 11.17	$ 9.77	$ 8.67	$ 7.80
$ 12,068.00	$ 34.87	$ 26.01	$ 20.74	$ 17.25	$ 14.76	$ 12.90	$ 11.46	$ 10.30
$ 13,575.00	$ 44.13	$ 32.92	$ 26.25	$ 21.82	$ 18.68	$ 16.32	$ 14.50	$ 13.04
$ 14,355.00	$ 49.35	$ 36.81	$ 29.35	$ 24.40	$ 20.89	$ 18.25	$ 16.21	$ 14.58
$ 14,513.00	$ 50.44	$ 37.62	$ 30.00	$ 24.95	$ 21.35	$ 18.66	$ 16.57	$ 14.90
$ 16,000.00	$ 61.30	$ 45.73	$ 36.46	$ 30.32	$ 25.95	$ 22.68	$ 20.14	$ 18.11
$ 16,391.00	$ 64.34	$ 47.99	$ 38.27	$ 31.82	$ 27.23	$ 23.80	$ 21.14	$ 19.01
$ 16,958.00	$ 68.86	$ 51.37	$ 40.96	$ 34.06	$ 29.15	$ 25.47	$ 22.62	$ 20.35
$ 17,720.00	$ 75.19	$ 56.09	$ 44.72	$ 37.19	$ 31.83	$ 27.82	$ 24.70	$ 22.22
$ 19,245.00	$ 88.69	$ 66.15	$ 52.75	$ 43.86	$ 37.54	$ 32.81	$ 29.14	$ 26.20
$ 19,403.00		$ 67.25	$ 53.62	$ 44.59	$ 38.16	$ 33.35	$ 29.62	$ 26.64
$ 21,000.00		$ 78.77	$ 62.81	$ 52.23	$ 44.70	$ 39.07	$ 34.69	$ 31.20
$ 21,500.00		$ 82.57	$ 65.84	$ 54.75	$ 46.85	$ 40.95	$ 36.37	$ 32.71
$ 21,848.00		$ 85.26	$ 67.99	$ 56.53	$ 48.38	$ 42.28	$ 37.55	$ 33.77
$ 23,000.00		$ 94.49	$ 75.34	$ 62.65	$ 53.62	$ 46.86	$ 41.62	$ 37.43
$ 24,293.00		$ 105.41	$ 84.05	$ 69.89	$ 59.82	$ 52.28	$ 46.43	$ 41.75
$ 24,500.00		$ 107.22	$ 85.49	$ 71.09	$ 60.84	$ 53.17	$ 47.22	$ 42.47
$ 25,000.00		$ 111.64	$ 89.02	$ 74.02	$ 63.35	$ 55.36	$ 49.17	$ 44.22
$ 25,660.00		$ 117.61	$ 93.78	$ 77.98	$ 66.74	$ 58.33	$ 51.80	$ 46.59
$ 29,025.00			$ 119.99	$ 99.77	$ 85.39	$ 74.63	$ 66.28	$ 59.61
$ 30,040.00			$ 128.53	$ 106.87	$ 91.46	$ 79.94	$ 70.99	$ 63.85
$ 32,180.00			$ 147.49	$ 122.64	$ 104.96	$ 91.73	$ 81.47	$ 73.27
$ 33,915.00				$ 136.22	$ 116.58	$ 101.89	$ 90.49	$ 81.38
$ 37,700.00				$ 168.33	$ 144.06	$ 125.90	$ 111.81	$ 100.56
$ 38,700.00				$ 177.38	$ 151.80	$ 132.67	$ 117.82	$ 105.96
$ 38,805.00					$ 152.63	$ 133.39	$ 118.46	$ 106.54
$ 43,695.00					$ 193.51	$ 169.13	$ 150.20	$ 135.08
$ 44,060.00					$ 196.76	$ 171.97	$ 152.72	$ 137.35
$ 45,220.00					$ 207.26	$ 181.14	$ 160.87	$ 144.68
$ 48,520.00						$ 208.54	$ 185.20	$ 166.56
$ 48,585.00						$ 209.10	$ 185.70	$ 167.01
$ 51,740.00						$ 237.14	$ 210.60	$ 189.41
$ 54,680.00							$ 235.22	$ 211.54
$ 56,780.00							$ 253.63	$ 228.10
$ 58,260.00							$ 267.03	$ 240.15
$ 64,780.00								$ 296.91

Appendix D: Geographic Location of Bexar County Families below Federal Poverty Level



Data Classes

Percent

- 0.0 - 4.6
- 5.1 - 10.3
- 11.5 - 18.1
- 18.9 - 26.4
- 30.4 - 38.8

Features

- Major Road
- Street
- Stream/Waterbody
- Stream/Waterbody

Items in gray text are not visible at this zoom level

Note. U.S. Census Bureau, (2005). American Community Survey (ACS):Bexar County Data Set.

Appendix E: Demographic Data General Characteristics: 2004 Bexar County, Texas

Table E.
General Characteristics: 2004 Bexar County, Texas
Data Set: 2004 American Community Survey
Geographic Area: Bexar County, Texas
NOTE. Data are limited to the household population and exclude the population living in institutions, college dormitories, and other group quarters. For information on confidentiality protection, sampling error, nonsampling error, and definitions, see Survey Methodology.

Selected Economic Characteristics: 2004	Estimate	Lower Bound	Upper Bound
EMPLOYMENT STATUS			
Population 16 years and over	**1,085,254**	**1,081,118**	**1,089,390**
In labor force	704,843	692,534	717,152
Civilian labor force	693,099	680,383	705,815
Employed	631,441	617,316	645,566
Unemployed	61,658	53,411	69,905
Armed Forces	11,744	8,652	14,836
Not in labor force	380,411	367,426	393,396
Civilian labor force	**693,099**	**680,383**	**705,815**
Unemployed	8.9	7.7	10.1
Females 16 years and over	**569,151**	**565,936**	**572,366**
In labor force	324,793	316,655	332,931
Civilian labor force	320,239	312,128	328,350
Employed	293,817	284,951	302,683
Own children under 6 years	**139,212**	**133,255**	**145,169**
All parents in family in labor force	79,144	71,987	86,301
Own children 6 to 17 years	**245,382**	**238,308**	**252,456**
All parents in family in labor force	162,281	149,500	175,062
Population 16 to 19 years	**83,785**	**79,270**	**88,300**
Not enrolled in school and not a H.S. graduate	9,595	6,571	12,619
Unemployed or not in the labor force	5,966	3,367	8,565
COMMUTING TO WORK			
Workers 16 years and over	**615,881**	**601,439**	**630,323**
Car, truck, or van -- drove alone	494,829	479,859	509,799
Car, truck, or van – carpooled	65,152	53,574	76,730
Public transportation (excluding taxicab)	11,114	7,008	15,220
Walked	16,472	10,967	21,977
Other means	8,829	5,184	12,474

Table E. *General Characteristics: 2004 Bexar County, Texas continued*			
Worked at home	19,485	14,535	24,435
Mean travel time to work (minutes)	21.6	20.9	22.3
Employed civilian population 16 years and over	**631,441**	**617,316**	**645,566**
OCCUPATION			
Management, professional, and related occupations	202,952	188,682	217,222
Service occupations	113,474	102,839	124,109
Sales and office occupations	180,819	167,263	194,375
Farming, fishing, and forestry occupations	871	0	2,021
Construction, extraction, maintenance and repair occupations	70,502	60,846	80,158
Production, transportation, and material moving occupations	62,823	51,963	73,683
INDUSTRY			
Agriculture, forestry, fishing and hunting, and mining	1,963	570	3,356
Construction	50,419	41,741	59,097
Manufacturing	44,120	34,574	53,666
Wholesale trade	29,250	24,322	34,178
Retail trade	87,608	76,881	98,335
Transportation and warehousing, and utilities	26,549	22,232	30,866
Information	13,826	10,359	17,293
Finance and insurance, and real estate and rental and leasing	61,389	53,938	68,840
Professional, scientific, and management, and administrative and waste management services	61,166	53,084	69,248
Educational services, and health care, and social assistance	125,802	114,785	136,819
Arts, entertainment, and recreation, and accommodation, and food services	64,709	56,405	73,013
Other services, except public administration	32,964	26,694	39,234
Public administration	31,676	25,814	37,538
CLASS OF WORKER			
Private wage and salary workers	490,440	474,520	506,360
Government workers	98,465	88,541	108,389
Self-employed workers in own not incorporated business	42,123	35,504	48,742
Unpaid family workers	413	0	892

Table E. *General Characteristics: 2004 Bexar County, Texas continued*

INCOME AND BENEFITS (IN 2004 INFLATION-ADJUSTED DOLLARS)			
Total households	**512,627**	**505,825**	**519,429**
Less than $10,000	60,075	52,180	67,970
$10,000 to $14,999	28,678	23,742	33,614
$15,000 to $24,999	66,200	59,310	73,090
$25,000 to $34,999	73,171	63,424	82,918
$35,000 to $49,999	86,918	78,776	95,060
$50,000 to $74,999	88,438	80,197	96,679
$75,000 to $99,999	46,102	40,448	51,756
$100,000 to $149,999	41,817	36,160	47,474
$150,000 to $199,999	8,313	5,671	10,955
$200,000 or more	12,915	9,743	16,087
Median household income (dollars)	39,694	37,877	41,511
Mean household income (dollars)	54,536	51,832	57,240
With earnings	422,956	415,300	430,612
Mean earnings (dollars)	53,491	50,678	56,304
With Social Security	119,375	113,872	124,878
Mean Social Security income (dollars)	11,474	10,827	12,121
With retirement income	95,489	88,661	102,317
Mean retirement income (dollars)	21,404	19,871	22,937
With Supplemental Security Income	20,191	15,850	24,532
Mean Supplemental Security Income (dollars)	6,379	5,416	7,342
With cash public assistance income	13,728	10,346	17,110
Mean cash public assistance income (dollars)	2,084	1,435	2,733
With Food Stamp benefits in the past 12 months	54,968	46,532	63,404
Families	**361,621**	**349,790**	**373,452**
Less than $10,000	31,641	24,521	38,761
$10,000 to $14,999	14,772	10,605	18,939
$15,000 to $24,999	43,401	36,898	49,904
$25,000 to $34,999	44,106	36,724	51,488
$35,000 to $49,999	61,281	54,150	68,412
$50,000 to $74,999	69,740	62,620	76,860
$75,000 to $99,999	40,485	34,917	46,053
$100,000 to $149,999	37,220	31,699	42,741
$150,000 to $199,999	7,198	4,982	9,414
$200,000 or more	11,777	8,529	15,025
Median family income (dollars)	46,193	43,385	49,001
Mean family income (dollars)	62,473	58,801	66,145
Per capita income (dollars)	20,483	19,637	21,329

Table E. *General Characteristics: 2004 Bexar County, Texas continued*

Nonfamily households	**151,006**	**140,879**	**161,133**
Median nonfamily income (dollars)	26,763	25,329	28,197
Mean nonfamily income (dollars)	33,865	31,532	36,198
Median earnings:	**22,101**	**21,305**	**22,897**
Male full-time, year-round workers (dollars)	36,175	33,942	38,408
Female full-time, year-round workers (dollars)	28,394	27,235	29,553
PERCENTAGE OF FAMILIES AND PEOPLE WHOSE INCOME IN THE PAST 12 MONTHS IS BELOW THE POVERTY LEVEL			
All families	14.6	12.1	17.1
With related children under 18 years	22	18.1	25.9
With related children under 5 years only	24.1	15.4	32.8
Married couple families	8.4	6.3	10.5
With related children under 18 years	13	9.6	16.4
With related children under 5 years only	19.1	9.9	28.3
Families with female householder, no husband present	36.8	29.7	43.9
With related children under 18 years	44.9	36.4	53.4
With related children under 5 years only	38.5	20.3	56.7
All people	17.2	14.8	19.6
Under 18 years	25.4	20.8	30
Related children under 18 years	25.3	20.7	29.9
Related children under 5 years	30.3	24	36.6
Related children 5 to 17 years	23.2	18.3	28.1
18 years and over	14	12.2	15.8
18 to 64 years	14.3	12.4	16.2
65 years and over	11.9	8.8	15
People in families	16.7	14	19.4
Unrelated individuals 15 years and over	22.5	19.5	25.5

Table E. *General Characteristics: 2004 Bexar County, Texas continued*

Source: U.S. Census Bureau, 2004 American Community Survey

Data are based on a sample and are subject to sampling variability. The degree of uncertainty for an estimate arising from sampling variability is represented through the use of a confidence interval. The interval shown here is a 90 percent confidence interval. The stated range can be interpreted roughly as providing a 90 percent probability that the interval defined by the lower and upper bounds contains the true value. In addition to sampling variability, the ACS estimates are subject to nonsampling error (for a discussion of nonsampling variability, see Accuracy of the Data). The effect of nonsampling error is not represented in these tables.

Notes:

· The number of householders does not necessarily equal the number of households because of differences in the weighting schemes for the population and occupied housing units.
· Employment and unemployment estimates may vary from the official labor force data released by the Bureau of Labor Statistics because of differences in survey design and data collection. For guidance on differences in employment and unemployment estimates from different sources go to Labor Force Guidance.
· Workers include members of the Armed Forces and civilians who were at work last week.
· Occupation codes are 4-digit codes, but are still based on Standard Occupational Classification 2000.
· Industry codes are 4-digit codes and are based on the North American Industry Classification System 2002. However, the Industry categories adhere to the guidelines issued in Clarification Memorandum No. 2, "NAICS Alternate Aggregation Structure for Use By U.S. Statistical Agencies," issued by the Office of Management and Budget.

Explanation of Symbols:

1. An '*' entry in the lower and upper bound columns indicates that too few sample observations were available to compute a standard error and thus the lower and upper bounds. A statistical test is not appropriate.
2. An '**' entry in the lower and upper bound columns indicates that no sample observations were available to compute a standard error and thus the lower and upper bounds. A statistical test is not appropriate.
3. An '-' entry in the estimate column indicates that no sample observations were available to compute an estimate.
4. An '-' following a median estimate means the median falls in the lowest interval of an open-ended distribution.
5. An '+' following a median estimate means the median falls in the upper interval of an open-ended distribution.
6. An '***' entry in the lower and upper bound columns indicates that the median falls in the lowest interval or upper interval of an open-ended distribution. A statistical test is not appropriate.
7. An '*****' entry in the lower and upper bound columns indicates that the estimate is controlled. A statistical test for sampling variability is not appropriate.
8. An 'N' entry in the estimate, lower bound, and upper bound columns indicates that data for this geographic area cannot be displayed because the number of sample cases is too small.

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14. ABSTRACT

Bexar County, low-income, uninsured parents with Medicaid- eligible children have been negatively impacted by reductions in Medicaid eligibility standards made by the Texas State Legislature in 2003 and the continuing reduction in local employer sponsored insurance. The cost for providing healthcare to this population has fallen to Bexar County residents through local taxes in support of the county hospital, University Health System. Alternatives to improve access to care for this population while reducing cost to the county are limited. A 1115 Medicaid waiver requiring a premium cost share with small business, employees and county indigent care funds is currently the best long term solution and will increase access and assist in mitigating some healthcare costs for the county.

15. SUBJECT TERMS

University Health System, Bexar County, Uninsured, Medicaid Waiver, Texas Medicaid

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